Public Employees Insurance Agency

2009 Medicare PFFS Plan Evidence Of Coverage

Your Medicare Health Benefits and Services as a Member of Advantra Freedom, A Medicare Advantage Private Fee For Service Plan offered through Coventry Health and Life Insurance Company.

July 1, 2009 - December 31, 2009

This booklet gives the details about your Medicare health and prescription drug coverage and explains how to get the prescription drug and health care you need. This booklet is an important legal document. Please keep it in a safe place.

Advantra Freedom Customer Service:

For help or information, please call Customer Service toll free:

1-877-337-4178

TTY: 1-866-386-2335

Monday through Friday, 8:00 a.m. – 10:00 p.m.

Eastern Standard Time

A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare supplement plan. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide health care services to you, except in emergencies. Providers can find the plan's terms and conditions on our website at: www.advantrafreedom.com.

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Section 1 Telephone numbers and other information for reference

How to contact Advantra Freedom Customer Service

If you have any questions or concerns, please call or write to Advantra Freedom Customer Service. We will be happy to help you.

Monday through Friday, 8:00 a.m. – 10:00 p.m.

Eastern Standard Time

CALL	1-877- 337-4178. This number is also on the cover of this booklet for easy reference. Calls to this number are free.
TTY	1-866-386-2335. This number requires special telephone equipment. It is on the cover of this booklet for easy reference. Calls to this number are free.
FAX	1-866-759-4415
WRITE	Advantra Freedom, Coventry Health Care, Inc., PO Box 7154, London, KY 40742-7154.

How to contact the Medicare program and the 1-800-MEDICARE (TTY 1-877-486-2048) helpline

Medicare is health insurance for people age 65 or older, under age 65 with certain disabilities, and any age with permanent kidney failure (called End-Stage Renal Disease or ESRD). The Centers for Medicare & Medicaid Services (CMS) is the Federal agency in charge of the Medicare Program. CMS contracts with and regulates Medicare Plans (including our Plan). Here are ways to get help and information about Medicare from CMS:

- Call 1-800-MEDICARE (1-800-633-4227) to ask questions or get a free information booklet from Medicare. TTY users should call 1-877-486-2048. Customer service representatives are available 24 hours a day, including weekends.
- Visit www.medicare.gov. This is the official government Web site for Medicare information**.** This Web site gives you up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare Prescription Drug Plans in your area. You can

also search under "Search Tools" for Medicare contacts in your state. Select "Helpful Phone Numbers and Web sites." If you don't have a computer, your local library or senior center may be able to help you visit this Web site using its computer.

(SHIP) – a state program that gives free local health insurance counseling to people with Medicare

"SHIP" stands for State Health Insurance Assistance Program. SHIPs are state organizations paid by the federal government to give free health insurance information and help to people with Medicare. SHIPs have different names depending on which state they are in. Your SHIP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. Your SHIP has information about Medicare Advantage Plans and about Medigap (Medicare supplement insurance) policies. This includes information about whether to drop your Medigap policy while enrolled in the Medicare Advantage plan. This also includes special Medigap rights for people who disenroll from a Medigap plan when they enroll in a Medicare Advantage plan for the first time but then leave the plan within 12 months and wish to buy another Medigap policy. (Section 13 has more information about your Medigap guaranteed issue rights).

Information on the West Virginia SHIP organization is listed below. If you would like information on SHIP programs in other states, you can call our Advantra Customer Service number on the front of this booklet or visit www.medicare.gov on the Web.

State Health Insurance Program

State	Address/Website	Phone
West Virginia	Bureau of Senior Services of West Virginia 1900 Kanawha Boulevard, East Charleston, WV 25305-0160 www.state.wv.us/seniorservices/	(877) 987-4463 (304) 558-2241 x17

Quality Improvement Organization – a group of doctors and health professionals in your state that reviews medical care and handles certain types of complaints from patients with Medicare

"QIO" stands for **Q**uality **I**mprovement **O**rganization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital stay is ending too soon. See Section 10 for more information about complaints.

Information on the West Virginia QIO is listed below. If you would like information on QIO programs in other states, you can call our Advantra Customer Service number on the front of this booklet or visit www.medicare.gov on the Web.

State	Organization/Address	Phone
West Virginia	**Harrisburg, PA Office** Commerce Court, Suite 320 2601 Market Place Street Harrisburg, PA 17110	(877) 346-6180 (717) 671-5425 Fax (717) 671-5970
	Pittsburgh, PA Office Penn Center West, Suite 220 Building 2, Penn Center Blvd. Pittsburgh, PA 15276 www.wvmi.org	(412) 787-9121
	Philadelphia, PA Office Bay Colony, Suite 100 585 East Swedesford Rd. Wayne, PA 19087	(610) 688-4668

Other Organizations (including Medicaid, Social Security Administration)

Medicaid Agency – a State Government Agency that handles health care programs for people with low incomes

Medicaid is a joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Some people with Medicare are also eligible for Medicaid. Most health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid also has programs that can help pay for your Medicare premiums and other costs, if you qualify.

Information on the West Virginia State Medicaid office is listed below. If you would like information on Medicaid offices in other states, you can call our Advantra Customer Service number on the front of this booklet or visit www.medicare.gov on the Web.

State Medicaid Office

State	Organization/Address	Phone
West Virginia	West Virginia Department of Health & Human Resources 350 Capitol Street Room 251 Charleston, WV 25326-3709 http://www.wvdhhr.org/bms/	(304) 558-1700

Social Security Administration

The Social Security Administration provides economic protection for Americans of all ages. Social Security programs include retirement benefits, disability, family benefits, survivors' benefits, and benefits for the aged, blind, and disabled. You can call the Social Security Administration toll free at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also visit www.ssa.gov on the Web.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you can call your local Railroad Retirement Board office or 1-800-808-0772 (calls to this number are free). TTY users should call 1-312-751-4701. You can also visit www.rrb.gov on the Web.

Employer (or "Group") Coverage

If you or your spouse get your benefits from your current or former employer or union, or from your spouse's current or former employer or union, call your employer's or union's benefits administrator or Customer Service if you have any questions about your employer/union benefits, plan premiums, or the open enrollment season. Important Note: You (or your spouses') employer/union benefits may change, or you or your spouse may lose the benefits, if you or your spouse enrolls in Medicare Part D. Call your employer's or union's benefits administrator or Customer Service to find out whether the benefits will change or be terminated if you or your spouse enrolls in Part D.

Welcome to *Advantra Freedom*!

We are pleased that you have chosen our Plan.

Advantra Freedom is a *Medicare Advantage Private Fee-For-Service plan*.

Thank you for your membership in Advantra Freedom; you are getting your health care and/or Medicare prescription drug coverage through our Plan. Advantra Freedom is not a "Medigap" Medicare Supplement Insurance policy.

Section 2 Getting the care you need, including some rules you must follow

Throughout the remainder of this Evidence of Coverage, we refer to Advantra Freedom as “Plan” or “our Plan.”

This Evidence of Coverage explains how to get your health care through Advantra Freedom.

You are still covered by Medicare, but you are getting your Medicare services as a member of Advantra Freedom.

This Evidence of Coverage will explain to you:

- What is covered by Advantra Freedom and what is not covered.
- How to get the care you need or your prescriptions filled including some rules you must follow.
- What you will have to pay for your health care or prescriptions.
- What to do if you are unhappy about something related to getting your covered services or prescriptions filled.

Eligibility Requirements

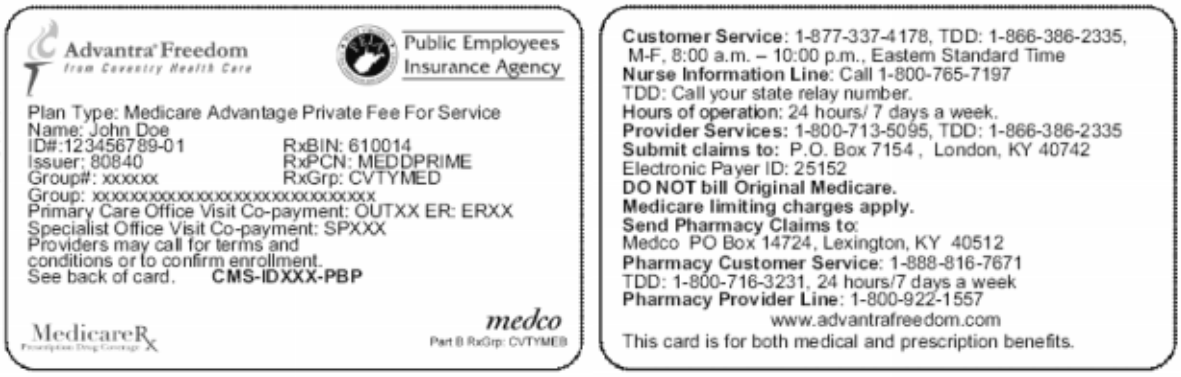
To be a member of Advantra Freedom, you must live in our service area, be entitled to Medicare Part A, and enrolled in Medicare Part B. If you currently pay a premium for Medicare Part A and Medicare Part B, you must continue paying your premium in order to keep your Medicare Part A and Medicare Part B and remain a member of this plan.

Use your plan membership card instead of your red, white, and blue Medicare card

Now that you are a member of Advantra Freedom, you must use the Advantra Freedom membership card for services covered by this plan and prescription drug coverage at network pharmacies.

Here is a **SAMPLE** card to show what it looks like:

(FRONT PFFS MAPD CARD) (BACK PFFS MAPD CARD)



While you are a plan member and using plan services, **you *must* use your plan membership card instead of your red, white, and blue Medicare card to get covered services.** (See Section 4 for a definition and list of covered services.) Keep your red, white, and blue Medicare card in a safe place in case you need it later. If you get covered services using your red, white, and blue Medicare card instead of your Advantra Freedom membership card while you are a plan member, the Medicare Program will not pay for these services and you may have to pay the full cost yourself and then submit a claim form to Advantra Freedom to be reimbursed up to the Medicare allowed amount minus any of your member responsibility.

Please carry your Advantra Freedom membership card with you at all times and remember to show your card when you get covered services, items and drugs. If your membership card is ever damaged, lost, or stolen, call Customer Service right away and we will send you a new card.

Help us keep your membership record up-to-date

Advantra Freedom has a membership record about you as a plan member. Doctors, hospitals, pharmacists and other plan providers use this membership record to know what services or drugs are covered for you. Your membership record has information from your PEIA enrollment form, including your address and telephone number. It shows your specific Advantra Freedom coverage and other information. Section 9 tells how we protect the privacy of your personal health information.

Please help us keep your membership record up-to-date by letting Customer Service know right away if there are any changes to your name, address, or phone number, or if you go into a nursing home. Also, tell Customer Service about any changes in health insurance coverage you have from other sources, such as from your employer, your spouse's employer, workers' compensation, Medicaid, or liability claims, such as claims from an automobile accident. Call the number on the cover of this booklet to contact Customer Service.

Getting care from doctors, specialists and hospitals

You may receive care from any doctor, specialist or hospital in the U.S. who is eligible to be paid by Medicare and accepts Advantra Freedom terms and conditions of payment. Advantra Freedom covers you for all Medicare A and B services and the supplemental benefits described in this document. You may also receive renal dialysis (kidney) services from any dialysis provider in the U.S. who is eligible to be paid by the Medicare program. If a particular provider does not accept your plan's terms and conditions of payment you must seek care from another provider who will. If you have any questions about what services Advantra Freedom covers or if a particular provider can be paid by Advantra Freedom you can contact us at Advantra Freedom. Note: If you receive hospital care, the hospital is required to provide you with a notice of anticipated cost sharing if your expected cost sharing amount for that admission will be $500 or greater.

Getting care when you travel or are away from the plan's service area

You may go to any eligible doctor or hospital in the U.S. that is willing to provide care and accepts Advantra Freedom's terms and conditions of participation. If you require dialysis services, you may go to any dialysis provider in the U.S. that is eligible to be paid by Medicare and accepts Advantra Freedom's terms and conditions of payment. When you go to a doctor or hospital, be sure to show them your Advantra Freedom PFFS enrollment card. The card ensures that the provider has a reasonable opportunity to obtain the terms and conditions of payment under the plan. If the doctor or hospital decides to treat you, you are only required to pay the cost sharing amount allowed by Advantra Freedom. The doctor or hospital will bill Advantra Freedom for the rest of its fee. You can call Advantra Freedom at the number on the cover of this booklet in advance of receiving health care services and we will provide an advance coverage determination for the care you need. You may also ask us for a coverage decision in writing confirming if the service will be paid for by Advantra Freedom.

What if your doctor will not furnish your care as a member of Advantra Freedom?

Sometimes a doctor, specialist, hospital, clinic, or other provider you are using might decide to not participate in Advantra Freedom. This could occur because your doctor has decided to not accept Advantra Freedom's terms and conditions of payment. If this happens, you will have to switch to another provider who is willing to treat you as a member of Advantra Freedom or you can continue to see the same provider and possibly be charged an additional 15% above Medicare allowable amount. If you continue to see the same provider and pay out of pocket, you will need to submit a claim form to be reimbursed up to Medicare allowed amount minus any of your member responsibility. If you need help finding a provider who will accept Advantra Freedom's terms and conditions of payment, please contact us at the number on the front of this booklet and we will provide assistance.

Section 3 Getting care if you have a medical emergency or an urgent need for care

What is a "medical emergency"?

A "medical emergency" is when **you reasonably believe that your health is in serious danger —** when every second counts. A medical emergency includes severe pain, a bad injury, a serious illness, or a medical condition that is quickly getting much worse.

What should you do if you have a medical emergency?

If you have a medical emergency:

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. **You do <u>not</u> need to get approval or a referral first from your PCP (<u>P</u>rimary <u>C</u>are <u>P</u>hysician) or other plan provider.** (Section 2 tells about your PCP and plan providers.)

What is covered if you have a medical emergency?

- You can get covered emergency medical care whenever you need it, anywhere in the world. See Section 6 for more information on how we cover outpatient prescription drugs in an emergency situation while you are outside the service area.
- **Ambulance** services are covered in situations where other means of transportation in the United States would endanger your health.

What if it wasn't really a medical emergency?

Sometimes it can be hard to know if you have a real medical emergency. For example, you might go in for emergency care—thinking that your health is in serious danger — and the doctor may say that it was not a medical emergency after all. If you decide to get follow-up care from the provider treating you, then you should advise them of your enrollment in Advantra Freedom as soon as possible. Your plan will pay for all medically necessary plan covered services furnished by the provider.

Advantra Freedom also covers urgently needed care that you get from any provider. (See Section 6 for more information on filling your prescription drugs when you are getting urgently needed care.)

Section 4 Benefits chart

A list of the covered services you get as a member of Advantra Freedom

What are "covered services"?

This section describes the medical benefits and coverage you get as a member of Advantra Freedom through PEIA. "Covered services" means the medical care, services, supplies, and equipment that are covered by Advantra Freedom. This section has a Benefits Chart that gives a list of your covered services.

The section that follows (Section 5) tells about services that are ***not*** covered (these are called "exclusions").

You can get covered benefits from any provider qualified to furnish the benefit in question and who is willing to accept Advantra Freedom's terms and conditions of payment. We urge you to call Customer Service at the phone number on the cover of this booklet to ask if a particular service is covered by your plan. Your plan does not have to pay for services that are not covered by the plan.

There are some conditions that apply in order to get covered services

Some general requirements apply to *all* covered services

The covered services listed in the Benefits Chart in this section are covered only when *all* requirements listed below are met:

- Services must be provided according to the Medicare coverage guidelines established by the Medicare Program.
- The medical care, services, supplies, and equipment that are listed as covered services must be medically necessary. Certain preventive care and screening tests are also covered.
- The exceptions are care for medical emergency, urgently needed services outside the service area, and renal (kidney) dialysis you get when you are outside the Plan's service area.

Benefits Chart – a list of covered services

Benefits chart – your covered services	**What you must pay** when you get these covered services
Annual Individual Medical Out of Pocket Maximum	**$750**
Inpatient Services	
Inpatient hospital care (Includes Substance Abuse & Rehab services) For more information about hospital care, see Section 7. Advantra Freedom covers an unlimited number of medically necessary hospital days. Covered services include, but are not limited to, the following: • Semiprivate room (or a private room if medically necessary). • Meals including special diets. • Regular nursing services. • Costs of special care units (such as intensive or coronary care units). • Drugs and medications. • Lab tests. • X-rays and other radiology services. • Necessary surgical and medical supplies. • Use of appliances, such as wheelchairs. • Operating and recovery room costs. • Physical therapy, occupational therapy, and speech therapy services. • *Under certain conditions, the following types of transplants are covered:* Corneal, kidney, pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, intestinal/multivisceral. See Section 7 for more information about transplants.	$100 co-payment per admission Substance Abuse & Rehab days are not limited

Benefits chart – your covered services	**What you must pay** when you get these covered services
• Blood – including storage and administration. Coverage of whole blood and package red cells begins with the first pint of blood. • Physician Services.	
Inpatient mental health care Includes mental health care services that require a hospital stay. Medicare beneficiaries may receive only 190 days in a Psychiatric Hospital in a lifetime.	$100 co-payment per admission 190 days lifetime maximum Substance Abuse days are not limited
Skilled nursing facility care For more information about skilled nursing facility care, see Section 7. No prior hospital stay is required. Covered services include, but are not limited to, the following: • Semiprivate room (or a private room if medically necessary). • Meals, including special diets. • Regular nursing services. • Physical therapy, occupational therapy, and speech therapy. • Drugs (this includes substances that are naturally present in the body, such as blood clotting factors). • Blood – including storage and administration. Coverage of whole blood and package red cells begins with the first pint of blood. • Medical and surgical supplies. • Laboratory tests. • X-rays and other radiology services. • Use of appliances such as wheelchairs. • Physician services.	$0 co-payment You are covered for 100 days each benefit period No prior hospital stay required A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Home health care For more information about home health care, see Section 7. *Home Health Agency Care:* • Part-time or intermittent skilled nursing and home health aide services. • Physical therapy, occupational therapy, and speech therapy. • Medical social services. • Medical equipment and supplies.	$0 co-payment
Hospice care For more information about hospice services, see Section 7. • Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Medicare. • Home care. • Hospice consultation services (one time only) for a terminally ill individual who has not elected the hospice benefit. • 5% coinsurance as permitted by Medicare for Hospice RS or respite services. Original Medicare pays the hospice for hospice services provided.	You must receive care from a Medicare-certified hospice.

Outpatient Services	
Physician services, including doctor office visits • Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center. • Consultation, diagnosis, and treatment by a specialist. • Second opinion by another plan provider prior to surgery. • Outpatient hospital services. • Non-routine dental care provided by a dentist (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a doctor).	$10 co-payment for each Primary Care Physician office visit $20 co-payment for each Specialist office visit Services received in the office setting that are considered surgical care, may result in a $50 office surgery co-payment.
Chiropractic services • Manual manipulation of the spine to correct subluxation.	$0 co-payment for manual manipulation of the spine to correct subluxation. No visit limit Other acute treatment by manipulation subject to 20 visit maximum with a $20 office visit co-payment
Podiatry services • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). Routine foot care covered for members with certain medical conditions affecting the lower limbs, such as diabetes.	$20 office visit co-payment Services received in the office setting that are considered surgical care, may result in a $50 office surgery co-payment.

Outpatient mental health care (including Partial Hospitalization Services) Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other mental health care professional as allowed under applicable state laws. "Partial hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	$0 co-payment Unlimited visits
Outpatient substance abuse services	$0 co-payment Unlimited visits
Outpatient surgery/Office surgery	$50 co-payment This copayment will apply to surgeries performed in an outpatient setting, including the doctor's office.
Ambulance services Includes ambulance services to an institution (like a hospital or SNF), from an institution to another institution, from an institution to your home, and services dispatched through 911, where other means of transportation could endanger your health.	$0 co-payment
Emergency care For more information, see Section 3. Per Medicare guidelines, member payment for emergent care may not exceed $50. • World wide coverage	$50 co-payment
Urgently needed care For more information, see Section 3. • Worldwide coverage.	$0 co-payment

Outpatient rehabilitation services *(cardiac rehabilitation, physical therapy, occupational therapy, and speech and language therapy)* Cardiac rehabilitation therapy covered for patients who have had a heart attack in the last 12 months, have had coronary bypass surgery, and/or have stable angina pectoris.	$0 co-payment Unlimited visits
Durable medical equipment and related supplies This includes wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizers, and walkers.	$0 co-payment
Prosthetic devices and related supplies (other than dental) which replace a body part or function These include colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" below for more detail.	$0 co-payment
Diabetes self-monitoring, training and supplies For all people who have diabetes (insulin and non-insulin users). • Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors. • One pair per calendar year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or insert. • Self-management training is covered under certain conditions. • *For persons at risk of diabetes.* Fasting plasma glucose test. Depending upon risk factors Medicare may cover up to two screenings per year	$0 co-payment for test strips and lancets Glucose monitors are provided to the member at no charge $0 co-payment for self-monitor training Syringes are covered under your prescription drug benefit

Medical nutrition therapy – for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by a doctor.	$0 co-payment
Outpatient diagnostic tests and therapeutic services and supplies • X-rays. • Radiation therapy. • Surgical supplies, such as dressings. • Supplies, such as splints and casts. Laboratory tests.	$0 co-payment
Preventive Care and Screening Tests	
Abdominal Aortic Aneurysm Screening A one-time screening ultrasound for people at risk. Medicare only covers this screening if you get a referral for it as a result of your "Welcome to Medicare" physical exam.	$0 co-payment
Bone mass measurements • For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	$0 co-payment
Colorectal screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. • Fecal occult blood test, every 12 months. For people at high risk of colorectal cancer, the following are covered: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months. For people not at high risk of colorectal cancer, the following is covered: • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy.	$0 co-payment

Immunizations • Pneumonia vaccine. • Flu shots, once a year in the fall or winter. As explained in Section 2, you can get this service on your own, without a referral from your PCP • *If you are at high or intermediate risk of getting Hepatitis B*: Hepatitis B vaccine. Other vaccines if you are at risk.	$0 co-payment for Pneumonia and Flu vaccines (Pharmacies may charge to administer. You may submit for reimbursement.) $0 co-payment for Hepatitis B vaccine
Mammography screening (as explained in Section 2, you can get this service on your own, without a referral from your PCP) One screening every 12 months	$0 co-payment
Pap smears, pelvic exams, and clinical breast exam Pap tests, pelvic exams, and clinical breast exams are covered once every 12 months.	100% coverage after $10 co-payment per office visit
Prostate cancer screening exams For men age 50 and older, the following are covered once every 12 months: • Digital rectal exam. • Prostate Specific Antigen (PSA) test.	$10 co-payment per office visit 100% coverage for approved lab services
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease).	$0 co-payment
Other Services	
Physical exams One exam every two years; more often if recommended by your physician	$10 co-payment per PCP office visit
Dialysis (Kidney) Services Inpatient and outpatient treatment services	$0 co-payment

Prescription Drugs – Part D ***See Section 6 - Section 6 explains about the prescription drug benefit, including rules you must follow to have prescriptions covered. Section 6 also tells about drugs that are not covered by this benefit.***	$75 individual deductible **Retail 30 day supply**: $5 Preferred Generic $15 Preferred Brand $50 Non-Preferred Generic and Brand $50 Specialty Drugs **Mail Order or participating WV retail pharmacy 90 day supply:** $10 Preferred Generic $30 Preferred Brand $100 Non-Preferred Generic or Brand $1,750 individual out-of-pocket maximum Once your individual out-of-pocket costs reach $1,750, you pay $0 for your prescription drugs for the remainder of the plan year If a generic is available the brand name drug cost is $5 plus the difference in cost between the generic and brand name drug. This ancillary charge does not count toward your out-of-pocket maximum. Catastrophic coverage begins when member's true out of pocket expense reaches $4,350. Since PEIA has a $1,750 individual maximum, catastrophic coverage is not applicable to your plan.

Prescription Drugs – Part B "Drugs" includes substances that are naturally present in the body, such as blood clotting factors. • Drugs that usually are not self-administered by the patient and are injected while receiving physician services. Advantra also covers some drugs that are "usually not self-administered" even if you inject them at home. • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by Advantra Freedom. • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you have had an organ transplant that was covered by Medicare. • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug. • Antigens. • Certain oral anti-cancer drugs and anti-nausea drugs. • Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, Erythropoietin (Epogen®) or Epoetin alfa, and Darboetin Alfa (Aranesp®). • Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in your home. ***Section 6 explains about the prescription drug benefit, including rules you must follow to have prescriptions covered. Section 6 also tells about drugs that are not covered by this benefit.***	$0 co-payment

Additional Benefits	
Dental services • Services by a dentist limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor. Impacted teeth and accident related only. Accident related must be within 6 months of accident for least expensive professionally acceptable alternative	$0 co-payment No routine coverage
Hearing services • Diagnostic hearing exams	$0 co-payment for Medicare covered services No coverage for routine hearing exams and hearing aids
Vision care • Outpatient physician services for eye care. *For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older:* glaucoma screening once per year. One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. **Coverage is limited to the amount that would have been paid by Original Medicare.**	$0 co-payment No routine coverage

Health and wellness education programs These are programs focused on clinical health conditions such as hypertension, cholesterol, asthma, and special diets. Programs designed to enrich the health & lifestyles of members include weight management, smoking cessation, fitness & stress management. Advantra Freedom wellness programs include: - Nurse line available 24 hours a day; 7 days a week - On-line fitness and wellness module - Newsletter - Advantra Forever Fit (Health Club Membership)	$0 co-payment
Transportation (Routine)	Not covered
Acupuncture and Massage Therapy • 20 visit maximum; subject to medical review	$0 co-payment
Optional Supplemental Benefits • Vision and dental offered through Flexible Benefits • Offered through PEIA on a voluntary basis during open enrollment	Member pays 100% of the premium
Transportation/Lodging/Meals • For in network transplant services only	Plan will pay up to $5,000 per plan year for travel, meals and lodging for patient and family member or friend.

PEIA Retiree Assistance Program

The PEIA retiree assistance program offers retirees the opportunity for decreased premiums as well as modifications to their benefits. If PEIA determines you qualify for this assistance, please refer to the chart below for your modified benefit information. For more information regarding qualifications, please contact PEIA.

Medical	Prescription Drugs
$300 Maximum out-of-pocket $2 co-payment for each PCP office visit $5 co-payment for each Specialist office visit	$250 Maximum out-of-pocket Co-payments: $3 Preferred Generic $10 Preferred Brand $50 Non-Preferred Generic or Brand $50 Specialty Drugs

What if you have problems getting services you believe are covered for you?

If you have any concerns or problems getting the services you believe are covered as a member, we want to help. Please call us at Customer Service at the telephone number on the cover of this booklet. You have the right to make a complaint if you have problems related to getting services or payment for services that you believe are covered as a member. See Section 10 for information about making a complaint.

Can your benefits change during the year?

Generally, your benefits will not change during the year. The Medicare program does not allow us to *decrease* your benefits during the calendar year. We are allowed to decrease your benefits only on July 1, at the beginning of the next plan year. The Medicare program must approve any *decreases* we make in your benefits. We will tell you 60 days in advance (in May) if there are going to be any increases or decreases in your benefits for the next plan year that begins on July 1.

At any time during the year, the Medicare program can change its national coverage. Since we cover what Original Medicare Plan covers, we would have to make any change that the Medicare Program makes. These changes could be to increase or decrease your benefits, depending on what change the Medicare Program makes.

Can the formulary change during the year?

We may make certain changes to our formulary during the year. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription. The kinds of formulary changes we may make include:

- Adding or removing drugs from the formulary
- Adding prior authorizations, quantity limits, and/or step-therapy restrictions on a drug
- Moving a drug to a higher or lower cost-sharing tier

If we remove drugs from the formulary, add prior authorizations, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, and you are taking the drug affected by the change, you will be permitted to continue taking that drug at the same level of cost-sharing for the remainder of the Plan year. However, if a brand name drug is replaced with a new generic drug, or our formulary is changed as a result of new information on a drug's safety or effectiveness, you may be affected by this change. We will notify you of the change at least 60 days before the date that the change becomes effective or provide you with a 60 day supply at the pharmacy. This will give you an opportunity to work with your physician to switch to an appropriate drug that we cover or request a formulary exception before the change to the formulary takes effect. If a drug is removed from our formulary because the drug has been recalled from the pharmacies, we will not give 60 days notice before removing the drug from the formulary. Instead, we will remove the drug from our formulary immediately and notify members taking the drug about the change as soon as possible.

Section 5 Medical care and services that are NOT covered or are limited (list of exclusions and limitations)

Introduction

The purpose of this section is to tell you about medical care and services that are not covered ("excluded") or are limited by our Plan. The list below tells about these exclusions and limitations. The list describes services that are not covered under *any* conditions, and some services that are covered only under specific conditions. (The Benefits Chart in Section 4 also explains about some restrictions or limitations that apply to certain services).

If you get services that are not covered, you must pay for them yourself

We will not pay for the exclusions that are listed in this section (or elsewhere in this booklet), and neither will Original Medicare, unless they are found upon appeal to be services that we should have paid or covered (appeals are discussed in Sections 10 and 11).

What services are not covered or are limited, by Advantra Freedom?

If you have any question whether our Plan will pay for a service, including inpatient hospital services, you have the right under law to have a written / binding advance coverage determination made for the service. Call Advantra Freedom at the number on the cover of this booklet and tell us you would like a decision if the service will be covered.

In addition to any exclusions or limitations described in the Benefits Chart in Section 4, or anywhere else in this booklet, **the following items and services are <u>not</u> covered except as indicated by Advantra Freedom:**

1. Services that are not covered under Original Medicare, *unless* such services are specifically listed as covered in Section 4.
2. Services that are not reasonable and necessary under Original Medicare Plan standards unless otherwise listed as a covered service. As noted in Section 4, we provide all covered services according to Medicare guidelines.
3. Emergency facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency. (See Section 3 for more information about getting care for a medical emergency).

4. Experimental or investigational medical and surgical procedures, equipment and medications determined by Advantra Freedom and Original Medicare not to be generally accepted by the medical community. A health product or service is deemed experimental or investigational if one or more of the following conditions are met:

    - Any drug not approved for use by the FDA; any drug that is classified as IND (investigational new drug) by the FDA; any drug requiring pre-authorization that is proposed for off-label prescribing;

    - Any health product or service that is subject to Investigational Review Board (IRB) review or approval;

    - Any health product or service whose effectiveness is unproven based on clinical evidence reported by peer-reviewed medical literature and by generally recognized academic experts;

See Section 7 for information about participation in clinical trials while you are a member of Advantra Freedom

5. Abortions are not covered Medicare procedures except in the following cases: (1) the pregnancy is the result of an act of rape or incest or (2) a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a physician, place the woman in danger or death unless an abortion is performed.
6. Allergy – Those non-Physician allergy services or associated expenses relating to an allergic condition including, but not limited to, installation of air filters, air purifiers, or air ventilation system cleaning.
7. Alternative Therapies – Alternative therapies, including, but not limited to, recreational, educational, music or sleep therapies and any related diagnostic testing.
8. Autopsy – Those services and associated expenses related to the performance of autopsies.
9. Christian Science Practitioners – Christian Science Practitioners' Services with the exception of the Medicare certified Religious Nonmedical Health Care Institutions Services (RNHCIs). See Section 7 for details.
10. Clinical Trials – Those Health Services and associated expenses for clinical trials that are not deemed to be qualified and covered under Original Medicare. Qualified clinical trials must meet Medicare coverage guidelines. See Section 7 for information about participation in clinical trials while you are a member of the Plan.

11. Cosmetic Surgery – Those Health Services and associated expenses for cosmetic procedures including, but not limited to, liposuction, breast augmentation, hair transplants, hair growth stimulants, sclerotherapy, pharmacological regimens, plastic surgery, and non-Medically Necessary dermatologic procedures and Reconstructive Surgery. Cosmetic procedures are those procedures which improve physical appearance, but which do not correct or materially improve a physiological function and are not Medically Necessary, except when it is needed for prompt repair of accidental injury or to improve the function of a malformed part of the body. Breast surgery and all stages of reconstruction for the breast on which a mastectomy was performed and, to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast are covered.

12. Counseling (Religious, Marital and Sex) – Services and treatment related to religious counseling, marital/relationship counseling, and sex therapy are not covered.

13. Custodial Care – Custodial care, domiciliary care, respite or rest care, which includes care that assists Members in the activities of daily living, like walking, getting in and out of bed, bathing, dressing, feeding, eating and using the bathroom; preparation of special diets; and supervision of medication that is usually self-administered is not covered, unless it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services, or; any health related services that do not seek to cure or which are provided during periods when the medical condition of the patient is not changing or which do not require continued administration by trained medical personnel.

14. Dental Services, Surgery and Implants – Those Health Services and associated expenses for dental surgery and implants – upper and lower jaw bone surgery and dental implants (including that related to the temporomandibular joint or craniomandibular joint), routine dental care (such as cleanings, X-rays, fillings, or dentures) or other dental services are excluded except as provided in Section 3 of the Benefits Chart, “Dental Services.”. Certain dental services that you get when you are in the hospital will be covered, if covered by Original Medicare.

15. Durable Medical Equipment (DME), Devices, Appliances and Supplies – Certain non-surgically implanted devices, appliances and supplies not covered under Original Medicare are excluded from coverage. Examples include, but are not limited to: purchase or rental of personal comfort items, including air conditioners, humidifiers, dehumidifiers, hypo-allergenic pillows, cervical pillows, wigs, fitness equipment, air purifiers, water purifiers and over-the-counter devices and/or supplies such as ACE wraps, elastic supports, finger splints and soft cervical collars are excluded. Deluxe versions of DME and medical devices are not covered unless Medically Necessary.

16. Elective or Voluntary Enhancement – Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic

purposes, anti-aging, mental performance, unless Medically Necessary. Other non-covered services include salabrasion, chemosurgery, laser surgery or other such skin abrasion procedures associated with removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne even when the medical or surgical treatment has been provided by the Plan for the condition resulting in the scar. This exclusion does not apply to hypertrophic scars that impair the functioning of a body part.

17. Enteral Feeding Food Supplement – The cost of outpatient enteral tube feedings or formula used as food supplements except in cases of permanent impairment. (See also Nutritional Supplements.)

18. Examinations – Those physical, psychiatric, psychological examination, testing, or treatments not otherwise covered, when such services are (1) for purposes of obtaining, maintaining or otherwise relating to career, education, travel, employment or insurance, marriage or adoption, or (b) relating to judicial or administrative proceedings or orders, or (c) which are conducted for purposes of medical research, or (d) to obtain or maintain a license of any type.

19. Experimental Organ Transplants – Those Health Services and associated expenses for organ transplants, procedures, and services associated with the preparation of such transplants, which are considered to be Experimental or Investigational Procedures by Medicare.

20. Foot Care – Those Health Services and associated expenses for routine foot care in connection with corns, calluses, flat feet, fallen arches or chronic foot strain, medical or surgical treatment of onychomycosis (nail fungus) are excluded.

21. Hair – Those services related to the analysis of hair unless used as a diagnostic tool to determine poisoning. Also excluded from coverage are hair transplants, hairstyling, wigs, hairpieces and hair prostheses, any treatment by which hair is grown, including those ordered by a Participating Physician.

22. Hearing Services And Supplies –Routine hearing examinations and those services associated expenses for hearing aids, the examination for prescribing and fitting hearing aids, hearing therapy, and any related diagnostic hearing tests, except as provided in Section 4 of the Benefits Chart, “Hearing Services.”

23. Homemaker Services and Charges imposed by immediate relatives or members of your household.

24. Hospice Services – Hospice services are not paid for by the Plan but reimbursed directly by Medicare when you enroll in a Medicare-certified Hospice. We will refer you to a Medicare-participating Hospice if you wish to elect such coverage. You may remain enrolled in the Plan even though you have elected Hospice coverage. You may continue to have your care unrelated to the terminal condition arranged through the Plan and you may also use a Contracted Medical Provider as your Hospice attending physician.

25. Hypnotherapy – Those hypnotism services or prolonged sleep services and associated expenses for treatment by hypnotism.

26. Immunization Services – Vaccinations, immunizations or treatments not otherwise covered, when such services are (a) for purposes of obtaining, maintaining or otherwise relating to career education, employment or insurance, marriage or adoption or (b) relating to judicial or administrative proceedings or (c) orders which are conducted for purposes of medical research or (d) to obtain or maintain a license of any type.

27. Infertility Treatment – Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices. (Medically necessary services for infertility are covered according to Original Medicare guidelines.)

28. Long-Term Care services beyond that which Medicare would cover, including, but not limited to, Skilled Nursing and respite care.

29. Meals delivered to your home.

30. Medicare Excess/Limiting Charge – This is the maximum amount a provider that does not accept Medicare assignment may charge. Providers that do not accept Medicare assignment are entitled to receive the Medicare limiting charge where not prohibited or limited by state law. Advantra Freedom will cover the Medicare limiting charge.

31. Naturopathic Services – The services and supplies provided by a naturopath and Homeopathic Services.

32. Nursing Home Charges – Room and board charges that are incurred while you reside in a long-term nursing home facility are not covered. Please note that any Medically Necessary services that are required while you are a resident of a nursing home will be covered when provided or authorized by the Plan.

33. Nutritional supplements are not covered, i.e., Ensure snacks, etc., except if the supplements are medically necessary and life sustaining.

34. Obesity Services – Those Health Services and associated expenses for procedures intended primarily for the treatment of obesity and morbid obesity including, but not limited to, gastric bypasses, gastric balloons, stomach stapling, jejunal bypasses, wiring of the jaw, and Health Services of a similar nature are not covered unless Medically Necessary and covered under Original Medicare. Health Services and associated expenses for weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature are not covered.

35. Occupational Injury – Those Health Services and associated expenses related to the treatment of an occupational injury or sickness for which the Plan Member is eligible to receive treatment under any Workers' Compensation or Occupational Disease laws or benefit plans.

36. Organ Donation – Those Medical or Hospital services, charges related to organ or tissue procurement, or any other charges or costs to you when you are an organ or tissue donor for another person. However, if not covered by any other source, the following Donor expenses are covered only when the organ recipient is a Member:

    - The removal of the organ from the donor;
    - Donor preparatory, pathologic and/or medical examinations; or
    - Post-surgical donor care.

37. Orthopedic/Supportive Devices for the Feet – Orthopedic shoes, unless they are part of a leg brace and are included in the cost of the leg brace. There is an exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease (as shown in Section 4, in the Benefits Chart under "Outpatient Medical services").

38. Outpatient Drugs and Injections – Drugs and medicines not covered under Medicare that can generally be self-administered with or without a doctor's prescription are not covered, except as provided for in Section 4 of the Benefits Chart, "Outpatient Prescription Drugs."

39. Private duty nursing services or nursing care on a full-time basis in your home or a facility, personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility, private room in a hospital, unless Medically Necessary.

40. Treatment of mental retardation, defects and deficiencies except for those mental health services considered to be Medically Necessary for the management of coexistent, behavior and psychiatric conditions.

41. Services Furnished under a Private Contract – Non-emergent services furnished by a physician or other practitioner who have filed with Medicare to provide Medicare-Covered Services to Medicare beneficiaries through private contracts.

42. Sexual Dysfunction – Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy or hyporgasmy.

43. Sex Transformation Services – Those Health Services and associated expenses for sex transformation operations regardless of any diagnosis of gender role disorientation or psychosexual orientation, including any treatment or studies related to sex transformation. Also excluded is hormonal support for sex transformation.

44. Speech Therapy – Those Health Services related to speech therapy except for restoration of speech after a stroke or brain injury or as treatment for a physical abnormality of the larynx, which has been appropriately diagnosed in the

judgment of the Plan. Services for the diagnosis of developmental delay are not covered.

45. Vitamins (except for legend prenatal vitamins, liquid or chewable pediatric vitamins; and any Medicare-covered vitamins, such as Vitamin B-12 shots to treat pernicious anemia and those additional vitamins specific to the PEIA formulary); minerals and/or food supplements.

46. Vision – Unless otherwise covered under your benefit plan, routine eye exam and eyeglasses (except after cataract surgery), contact lenses, radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services. Any service or material except as provided in Section 4 of the Benefits Chart, "Vision Care."

47. VA facilities - Services provided to veterans in Veteran's Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost sharing is more than the cost sharing required under Advantra Freedom, we will reimburse veterans for the difference. Members are still responsible for the Plan's cost-sharing amount.

Section 6 Coverage for Outpatient Prescription Drugs

This section describes your outpatient prescription drug coverage as a member of our Plan. We will explain what a formulary is and how to use it, our drug management programs, how much you will pay when you fill a prescription for a covered drug, and what an Explanation of Benefits is and how to get additional copies.

What drugs are covered by this Plan?

What is a formulary?

We have a formulary that lists most of the drugs that we cover. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy or through our network mail order pharmacy service and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage.

The drugs on the formulary are selected by our Plan with the help of a team of health care providers. We select the prescription therapies believed to be a necessary part of a quality treatment program. Both brand-name drugs and generic drugs are included on the formulary. A generic drug has the same active-ingredient formula as the brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs.

Not all drugs are included on the formulary. In some cases, the law prohibits coverage of certain types of drugs. (See "Drug Exclusions," later in this section, for more information about the types of drugs that cannot be covered under a Medicare Prescription Drug Plan.) The PEIA Advantra Freedom plan covers some additional drugs. Refer to your Advantra Freedom formulary for a partial listing of those drugs. In other cases, we have decided not to include a particular drug.

How do you find out what drugs are on the formulary?

You may call Customer Service to find out if your drug is on the formulary or to request a copy of the formulary. You can also get updated information about the drugs covered by us by visiting our Web site www.advantrafreedom.com. You may also visit the PEIA website for a copy of the formulary listing a www.westvirginia.com/peia.

What are drug tiers?

Drugs on our formulary are organized into different drug tiers, or groups of different drug types. Your co-insurance or co-payment depends on which drug tier your drug is in. You may ask us to make an exception (which is a type of coverage determination) to your drug's tier placement in certain circumstances. (See "Can the formulary change?" below).

Can the formulary change?

We may make certain changes to our formulary during the year. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription. The kinds of formulary changes we may make include:

- Adding or removing drugs from the formulary
- Adding prior authorizations, quantity limits, and/or step-therapy restrictions on a drug
- Moving a drug to a higher or lower cost-sharing tier

If we remove drugs from the formulary, add prior authorizations, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, and you are taking the drug affected by the change, you will be permitted to continue taking that drug at the same level of cost-sharing for the remainder of the Plan year. However, if a brand name drug is replaced with a new generic drug, or our formulary is changed as a result of new information on a drug's safety or effectiveness, you may be affected by this change. We will notify you of the change at least 60 days before the date that the change becomes effective or provide you with a 60 day supply at the pharmacy. This will give you an opportunity to work with your physician to switch to an appropriate drug that we cover or request a formulary exception before the change to the formulary takes effect. If a drug is removed from our formulary because the drug has been recalled from the pharmacies, we will not give 60 days notice before removing the drug from the formulary. Instead, we will remove the drug from our formulary immediately and notify members taking the drug about the change as soon as possible.

What if your drug is not on the formulary?

If your prescription is not listed on the formulary, you should first contact Customer Service to be sure it is not covered.

If Customer Service confirms that we do not cover your drug, you have three options:

- You may ask your doctor if you can switch to another drug that is covered by us. If you would like to give your doctor a list of covered drugs that are used to treat similar medical conditions, please contact Customer Service.
- You may ask us to make an exception (which is a type of coverage determination) to cover your drug. (See "What Is An Exception" in Section 12).
- You may pay out-of-pocket for the drug and request that the Plan reimburse you by requesting an exception (which is a type of coverage determination). If the exception request is not approved, the Plan is not obligated to reimburse you. If the exception is not approved, you may appeal the Plan's denial. (See Section 12 for more information on how to request an exception or appeal.)

If you recently joined this plan, you may be able to get a temporary supply of a drug you were taking when you joined our Plan if it is not on our formulary. The next section tells the rules governing obtaining temporary supplies of drugs.

Using plan pharmacies to get your prescription drugs covered by us

What are network pharmacies?

With few exceptions, **you must use network pharmacies to get your prescription drugs covered.**

- **What is a "network pharmacy?"** A "network pharmacy" is a pharmacy at which you can get your prescription drug benefits. We call them "network pharmacies" because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. Once you go to one, you are not required to continue going to the same pharmacy to fill your prescription; you can go to any of our network pharmacies. However, if you switch to a different network pharmacy, you must either have a new prescription written by a physician or have the previous pharmacy transfer the existing prescription to the new pharmacy if any refills remain.
- **What are "covered drugs?"** "Covered drugs" is the general term we use to mean all of the outpatient prescription drugs that are covered by our Plan. Covered drugs are listed in the formulary.

How do you fill a prescription at a network pharmacy?

To fill your prescription, you must show your Plan membership card at one of our network pharmacies. If you do not have your membership card with you when you fill your prescription, you may have to pay the full cost of the prescription (rather than paying just your co-payment). If this happens, you may ask us to reimburse you for our share of the cost by submitting a claim to us. To learn how to submit a paper claim, please refer to the paper claims process described at the end of this section.

The Pharmacy Directory gives you a list of Plan network pharmacies.

As a member of our Plan we will send you a Pharmacy Directory, which gives you a list of our network pharmacies. You can use it to find the network pharmacy closest to you. If you don't have the Pharmacy Directory, you can get a copy from Customer Service. They can also give you the most up-to-date information about changes in this Plan's pharmacy network. In addition, you can find this information on our Web site.

What if a pharmacy is no longer a "network pharmacy?"

Sometimes a pharmacy might leave the Plan's network. If this happens, you will have to get your prescriptions filled at another Plan network pharmacy. Please refer to your Pharmacy Directory or call Customer Service to find another network pharmacy in your area.

How do you fill a prescription through our Plan's network mail-order pharmacy service?

You can use our network mail-order pharmacy service to fill prescriptions for "maintenance drugs." These are drugs that you take on a regular basis, for a chronic or long-term medical condition. These are the only drugs available through our mail-order service.

When you order prescription drugs through our network mail-order pharmacy service, you must order at least a 30-day supply, and no more than a 90-day supply of the drug.

Generally, it takes us up to fourteen (14) days to process your order and ship it to you. However, sometimes your mail order may be delayed. The member should contact Customer Service to arrange for an interim supply of medication if appropriate.

You are not required to use our mail-order services to get an extended supply of maintenance drugs. You can also get an extended supply through some retail network pharmacies. Please call our Customer Service or look in your Pharmacy Directory, to find out which retail pharmacies offer an extended supply.

Filling prescriptions outside the network

We have network pharmacies outside of the service area where you can get your drugs covered as a member of our Plan. Generally, we only cover drugs filled at an out-of-network pharmacy in limited circumstances when a network pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at an out-of-network pharmacy. **Before you fill your prescription in these situations, call Customer Service to see if there is a network pharmacy in your area where you can fill your prescription**. If you do go to an out-of-network pharmacy for the reasons listed below, you may have to pay the full cost (rather than paying just your co-payment) when you fill your prescription. You may ask us to reimburse you for our share of the cost by submitting a claim form. You should submit a claim to us if you fill a prescription at an out-of-network pharmacy as any amount you pay will help you meet your deductible or out-of-pocket maximum limit.

NOTE: If we do pay for the drugs you get at an out-of-network pharmacy, you may still pay more for your drugs than what you would have paid if you went to an in-network pharmacy.

We will provide out-of-network coverage under the following circumstances:

- **Medical emergency**

  We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care. In this situation, you will have to pay the full cost (rather than paying just your co-payment) when you fill your prescription. You may ask us to reimburse you for our share of the cost by submitting a paper claim form. To

learn how to submit a paper claim, please refer to the paper claims process described below.

- **When you travel or are away from the Plan's service area**

  If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our network mail-order pharmacy service or through a retail network pharmacy that offers an extended supply.

  If you are traveling within the U.S. and you become ill, or run out of your prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules identified within this document and a network pharmacy is not available. In this situation, you will have to pay the full cost (rather than paying just your co-payment) when you fill your prescription. You may ask us to reimburse you for our share of the cost by submitting a claim form. To learn how to submit a paper claim, please refer to the paper claims process described below.

  Prior to filling your prescription at an out-of-network pharmacy, call our Customer Service to find out if there is a network pharmacy in the area where you are traveling. If there are no network pharmacies in that area, our Customer Service may be able to make arrangements for you to get your prescriptions from an out-of-network pharmacy.

We cannot pay for any prescriptions that are filled by pharmacies outside the United States, even for a medical emergency.

- **Other times you can get your prescription covered if you go to an out-of-network pharmacy**

  We will cover your prescription at an out-of-network pharmacy if at least one of the following applies:

  If you are unable to get a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.

  If you are trying to fill a covered prescription drug that is not regularly stocked at an eligible network retail or mail order pharmacy (these drugs include orphan drugs or other specialty pharmaceuticals).

Before you fill your prescription in any of these situations, call Customer Service to see if there is a network pharmacy in your area where you can fill your prescription. If you do go to an out-of-network pharmacy for the reasons listed above, you will have to pay the full cost (rather than paying just your co-payment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by

submitting a claim form. To learn how to submit a paper claim, please refer to the paper claims process described below.

How do you submit a paper claim?

When you go to a network pharmacy and use the Plan membership card, your claim is automatically submitted to us by the pharmacy. However, if you go to an out-of-network pharmacy and attempt to use the Plan membership card for one of the reasons listed above, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. When you return home, simply submit your claim and your receipt of payment to the following address:

Medco
P O Box 14724
Lexington, KY 40512

You may obtain paper claim forms by calling Customer Service.

If we do not receive your paper claims within 90 days of the fill date, we may deny the claim for failure to meet timely filing requirements. You have the right to appeal this and all other coverage determinations. See Section 12 for more information.

If you submit a paper claim to us, the claim is treated as a request for a coverage determination. If you are asking us to reimburse you for a prescription drug that is not on our formulary or is subject to coverage requirements or limits, your doctor may need to submit additional documentation supporting your request. See Section 12 to learn more about requesting coverage determinations.

Specialty pharmacies

Home infusion pharmacies

Our Plan will cover home infusion therapy if:

- Your prescription drug is on our Plan's formulary or a formulary exception has been granted for your prescription drug,
- Your prescription drug is not otherwise covered under our Plan's medical benefit,
- Our Plan has approved your prescription for home infusion therapy, and
- Your prescription is written by an authorized prescriber.

Please refer to your Pharmacy Directory to find a home infusion pharmacy provider in your area. For more information, please contact Customer Service.

Long-term care pharmacies

Generally, residents of a long-term care facility (like a nursing home)may get their prescription drugs through the facility's long-term care pharmacy or another network long-term care pharmacy. Please refer to your Pharmacy Directory to find out if your long-term care pharmacy is part of our network. If it is not, or for more information, please contact Customer Service.

Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) Pharmacies

Only Native Americans and Alaska Natives have access to Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) Pharmacies through our Plan's pharmacy network. Those other than Native Americans and Alaskan Natives may be able to access these pharmacies under limited circumstances (e.g. emergencies).

Please refer to your Pharmacy Directory to find an I/T/U pharmacy in your area. For more information, please contact Customer Service.

Transition Policy

New members in our Plan may be taking drugs that are not on our formulary, or that are subject to certain restrictions, such as prior authorization or step therapy. Current members may also be affected by changes in our formulary from one year to the next. Members should talk to their doctors to decide if they should switch to an appropriate drug that we cover or request a formulary exception (which is a type of coverage determination) in order to get coverage for the drug. See Section 12 to learn more about how to request an exception. While these new members might talk to their doctors to determine the right course of action, we may cover a temporary 30-day supply of the non-formulary or restricted drug in certain cases during the first 90 days of new membership. After we cover the temporary 30-day supply, we generally will not pay for these drugs as part of our transition policy again. We will provide you with a written notice after we cover your temporary supply. This notice will explain the steps you can take to request an exception and how to work with your doctor to decide if you should switch to an appropriate drug that we cover.

If a new member is a resident of a long-term-care facility (like a nursing home), we will cover a temporary 31-day transition supply (unless you have a prescription written for fewer days). If necessary, we will cover more than one refill of these drugs during the first 90 days a new member is enrolled in our Plan, when that member is a resident of a long-term-care facility. If a new member, who is a resident of a long-term-care facility and has been enrolled in our Plan for more than 90 days, needs a drug that is not on our formulary or is restricted, we will cover a temporary 31-day emergency supply of that drug (unless the prescription is for fewer days) while the new member pursues a formulary exception.

Transition for Existing Members:
This applies to currently enrolled members past the initial transition period of 90 days (see process outlined above).

1. **Annual changes to the tiers of medication.**
    - Should a medication you are currently taking be removed from the formulary, you and your prescribing physician will receive a letter informing them of the changes taking place sixty (60) days prior to the effective date. During this 60-day period, the enrollee will be able to obtain the medication at the pre-existing copay tier.

2. **Non-annual changes to medications may occur.**
    - If a medication is removed from the market, you and your physician will be notified, along with the therapeutically equivalent substitution on the same tier if applicable.
    - If a Part D medication is currently covered and receives a new FDA indication, the P&T Committee may change it to a different co-pay tier and/or require prior authorization and/or stepped therapy.
    - If a Part D medication is deemed to be unsafe.
    - You will be notified of these non-annual changes as soon as possible. Depending on the change, a 60-day period of transition may not be possible or appropriate. The notice to you and your physician will describe the specific transition process.

Please note that our transition policy applies only to those drugs that are “Part D drugs” and that are purchased at a network pharmacy. The transition policy cannot be used to purchase a non-Part D drug or drug out-of-network.

In some cases, we will contact you if you are taking a drug that is not on our formulary. We can give you the names of covered drugs that also are used to treat your condition so you can ask your doctor if any of these drugs are an option for your treatment.

Drug exclusions

By law, certain types of drugs or categories of drugs are not covered by Medicare Prescription Drug Plans. These drugs are not considered Part D drugs and may be referred to as "exclusions" or "non-Part D drugs." These drugs include:

Nonprescription drugs	Drugs when used for anorexia, weight loss or weight gain
Drugs when used to promote fertility	Drugs when used for cosmetic purposes or hair growth
Drugs when used for symptomatic relief of cough or colds except those additional drugs added to the PEIA formulary.	Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations and those additional drugs added to the PEIA formulary.
Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale	Barbiturates and benzodiazepines except for those additional drugs added to the PEIA formulary.
Drugs such as Viagra, Cialis, and Caverject, when used for the treatment of sexual or erectile dysfunction, except those additional drugs added to the PEIA formulary	

In addition, a Medicare Prescription Drug Plan cannot cover a drug that would be covered under Medicare Part A or Part B. (See "How does your enrollment in this Plan affect coverage for drugs covered under Medicare Part A or Part B?" below.)
Also, while a Medicare Prescription Drug Plan can cover off-label uses of a prescription drug, we cover the off-label use only in cases where the use is supported by certain reference book citations. Congress specifically listed the reference books that list whether the off-label use would be permitted.[1] If the use is not supported by one of these reference books (known as compendia), then the drug would be considered a non-Part D drug and would not be covered by our Plan.

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1 These compendia are: (1) American Hospital Formulary Service Drug Information; (2) United States Pharmacopoeia-Drug Information; and (3) the DRUGDEX Information System.

We offer additional coverage on some prescription drugs not normally covered in a Medicare Prescription Drug Plan. (This includes individual drugs that belong to the categories listed above). In addition, if you are receiving extra help from Medicare to pay for your prescriptions, the extra help will not pay for these drugs. Please refer to your formulary to find out which drugs we are offering additional coverage for or call Customer Service if you have any questions.

Some excluded drugs that are not typically covered under Part D that are covered under Advantra Freedom include:

- Alprazolam Tablets (0.25mg, 0.5mg, 1mg, 2mg)
- Clonazepam Tablets (0.5mg, 1mg, 2mg)
- Folic Acid Tablets (1mg)
- Levitra Tablets (2.5 mg, 5mg, 10 mg, 20mg)
- Lorazepam Tablets (0.5mg 1mg, 2mg)
- Phenobarbital Tablets (15mg, 16.2mg, 30mg, 32.4mg, 60mg, 64.8mg, 97.2mg, 100mg)
- Temazepam Capsules (7.5 mg, 15mg, 30mg)

Note: quantity limits and prior authorization may apply

How does your enrollment in this Plan affect coverage for the drugs covered under Medicare Part A or Part B?

Your enrollment in this Plan does not affect Medicare coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B even though you are enrolled in this Plan.
See your *Medicare & You* Handbook for more information about drugs that are covered by Medicare Part A and Part B.

Drug Management Programs

Utilization management

For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and pharmacists developed the following requirements and limits for our Plan to help us to provide quality coverage to our members:

Prior Authorization: We require you to get prior authorization for certain drugs. This means that your prescribing physician will need to get approval from us before you fill your prescription. If they do not get approval, we may not cover the drug.

Quantity Limits: For certain drugs, we limit the amount of the drug that will be covered based on current medical guidelines. For example, if a drug manufacturer recommends that a medication should be taken once weekly, we would provide coverage for 4 tablets

per prescription for 30 days. Other medications which are taken once daily would be limited to 30 tablets every 30 days. For maintenance medications we would allow a quantity sufficient to last the patient up to 90 days within these defined quantity limits.

Step Therapy: In some cases, we require you to first try one drug to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may require your doctor to prescribe Drug A first. If Drug A does not work for you, then we will cover Drug B.

Generic Substitution: When there is a generic version of a brand-name drug available, our network pharmacies will automatically give you the generic version, unless you or your doctor has told us that you must take the brand-name drug.

You can find out if the drug you take is subject to these additional requirements or limits by looking in the formulary or calling Customer Service. If your drug is subject to one of these additional restrictions or limits and your physician determines that you are not able to meet the additional restriction or limit for medical necessity reasons, you or your physician can request an exception (which is a type of coverage determination). (See Section 12 for more information about how to request an exception.)

Drug utilization review

We conduct drug utilization reviews for all of our members to make sure that they are receiving safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribe their medications. We conduct drug utilization reviews each time you fill a prescription and on a regular basis by reviewing our records. During these reviews, we look for medication problems such as:

- Possible medication errors
- Duplicate drugs that are unnecessary because you are taking another drug to treat the same medical condition
- Drugs that are inappropriate because of your age or gender
- Possible harmful interactions between drugs you are taking
- Drug allergies
- Drug dosage errors

If we identify a medication problem during our drug utilization review, we will work with your doctor to correct the problem.

Medication therapy management programs

We offer medication therapy management programs at no additional cost for members who have multiple medical conditions, who are taking many prescription drugs, or who have high drug costs. These programs were developed for us by a team of pharmacists and doctors. We use these medication therapy management programs to help us

provide better coverage for our members. For example, these programs help us make sure that our members are using appropriate drugs to treat their medical conditions and help us identify possible medication errors.

We offer medication therapy management program(s) for members that meet specific criteria. We may contact members who qualify for these programs. If we contact you, we hope you will join so that we can help you manage your medications. Remember, you do not need to pay anything extra to participate.

If you are selected to join a medication therapy management program, we will send you information about the specific program, including information about how to access the program.

How much do you pay for drugs covered by this Plan?

If you qualify for extra help with your drug costs, your costs for your drugs may be different than those described below. (See "What extra help is available?" later in this section and the "Evidence of Coverage Rider for those who get extra help paying for their prescription drugs" for more information.)

When you fill a prescription for a covered drug, you may pay part of the costs for your drug. The amount you pay for your drug depends on the type of drug it is, and whether you are filling your prescription at an in-network or out-of-network pharmacy. Each phase of the benefit and your drug costs for each coverage level is described below:

Initial Coverage Period

Yearly Deductible

You have a $75 individual annual deductible

Annual Out-of-Pocket Maximum

You have a $1,750 individual out-of-pocket maximum

During the **initial coverage period**, we will pay part of the costs for your covered drugs and you will pay the other part. The amount you pay when you fill a covered prescription is called the **co-payment**. Your **co-payment** will vary depending on the drug and where the prescription is filled.

Co-payment in the Initial Coverage Period

After you satisfy the deductible, you will have to pay the following for your prescription drugs:

Drug Tier	Retail Co-payment (30-day Supply)	Retail Co-payment (90-day Supply)	Mail-Order Co-payment (90-day supply)*
Tier 1 Preferred Generic	$5 co-payment	$10 co-payment	$10 co-payment
Tier 2 Preferred Brand	$15 co-payment	$30 co-payment	$30 co-payment
Tier 3 Non-Preferred Brand/Non Preferred Generic	$50 co-payment	$100 co-payment	$100 co-payment
Tier 4 Specialty Drugs	$50 co-payment	Not available	Not available

***You pay Mail Order co-payments (two payments for three months) for prescriptions filled at participating West Virginia retail pharmacies for a 90-day supply.**

After your individual costs reach $1,750, you play $0 for your prescriptions**.**

Catastrophic Coverage

Medicare Prescription Drug Plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend $4,350 out-of-pocket for the year. Your PEIA coverage pays 100% for your prescriptions once you've reached the $1,750 individual out of pocket. Since the $1,750 maximum out-of-pocket is less than the $4,350 initial coverage limit, catastrophic coverage does not apply.

What extra help is available?

Medicare provides "extra help" to pay prescription drug costs for people who meet specific income and resources limits. Resources include your savings and stocks, but not your home or car. If you qualify, you will get help paying for your Medicare drug plan's prescription co-payments.

Do you qualify for extra help?

People with limited income and resources may qualify for extra help one of two ways. The amount of extra help you get will depend on your income and resources.

1. You automatically qualify for extra help and don't need to apply. If you have full coverage from a state Medicaid program, get help from Medicaid paying your Medicare premiums (belong to a Medicare Savings Program), or get Supplemental

Security Income benefits, you automatically qualify for extra help and do not have to apply for it. Medicare mails letters monthly to people who automatically qualify for extra help.

2. You apply and qualify. You may qualify if your yearly income in 2008 is less than $15,600 (single with no dependents) or $21,000 (married and living with your spouse with no dependents), and your resources are less than $11,990 (single) or $23,970 (married and living with your spouse). Resources include your savings and stocks but not your home or car. If you think you may qualify, call Social Security at 1-800-772-1213, visit www.socialsecurity.gov on the web, or apply at your State Medical Assistance (Medicaid) office. TTY users should call 1-800-325-0778. After you apply, you will get a letter in the mail letting you know if you qualify and what you need to do next.

The above income and resource amounts are for 2008 and may change in 2009. If you live in Alaska or Hawaii, or pay at least half of the living expenses of dependent family members, income limits are higher.

How do my costs change when I qualify for extra help?

The extra help you get from Medicare will help you pay for Advantra Freedom's prescription co-payments. The amount of extra help you get is based on your income and resources.

If you qualify for extra help, we will send you by mail an "Evidence of Coverage Rider for those who receive extra help from Medicare for their prescription drugs" that explains your costs as a member of our Plan. If the amount of your extra help changes during the year, we will also mail you an updated "Evidence of Coverage Rider for those who receive extra help from Medicare for their prescription drugs".

How do you get more information?

For more information on who can get extra help with prescription drug costs and how to apply, call the Social Security Administration at 1-800-772-1213, or visit www.socialsecurity.gov on the Web. TTY/TDD users should call 1-800-325-0778.

In addition, you can look at the 2007 *Medicare & You* Handbook, visit www.medicare.gov on the Web, or call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

If you have any questions about our Plan, please refer to our Customer Service numbers listed on the cover and in the Benefits at a Glance section. Or, visit our website.

How is your out-of-pocket cost calculated?

What type of prescription drug payments count toward your out-of-pocket costs?

The following types of payments for prescription drugs can count toward your out-of-pocket costs and help you qualify for catastrophic coverage, so long as the drug you are paying for is a Part D drug on the formulary (or if you get a favorable decision on a coverage determination, exception request or appeal), obtained at a network pharmacy (or you have an approved claim from an out-of-network pharmacy); and otherwise meets our coverage requirements:

- Your coinsurance or co-payments.

Your PEIA coverage pays 100% for your prescriptions once you've reached the $1,750 individual out of pocket. Since the $1,750 maximum out-of-pocket is less than the $4,350 initial coverage limit, catastrophic coverage does not apply.

Purchases that will not count toward your out-of-pocket costs include:

- Prescription drugs purchased outside the United States and its territories;
- Prescription drugs not covered by the Plan
- Ancillary charges for brand name drugs fills when a generic drug is available. (Ancillary charges equal the generic co-payment plus the difference in cost between the generic and brand name drug.)

We offer additional coverage on some prescription drugs not normally covered in a Medicare Prescription Drug Plan. This includes individual drugs that belong to the categories listed above. In addition, if you are receiving extra help from Medicare to pay for your prescriptions, the extra help will not pay for these drugs. Please refer to your formulary to find out which drugs we are offering additional coverage for or call Customer Service if you have any questions.

Who can pay for your prescription drugs, and how do these payments apply to your out-of-pocket costs?

Any payments you make for drugs covered by PEIA count toward your out-of-pocket costs. In addition, when the following individuals or organizations pay your costs for such drugs, these payments will count toward your out-of-pocket costs:

- Family members or other individuals;
- Qualified State Pharmacy Assistance Programs (SPAPs)
- Medicare programs that provide extra help with prescription drug coverage; and
- Most charities or charitable organizations. Please note that if the charity is established, run or controlled by your current or former employer or union, the payments usually will **not** count toward your out-of-pocket costs.

Payments made by the following do **not** count toward your out-of-pocket costs:

- Group Health Plans;
- Insurance Plans and government funded health programs (e.g. TRICARE, the VA, the Indian Health Service, AIDS Drug Assistance Programs); and
- Third party arrangements with a legal obligation to pay for prescription costs (e.g., Workers Compensation).

If you have coverage from a third party such as those listed above that pays a part of or all of your out-of-pocket costs, you must disclose this information to us.

We will be responsible for keeping track of your out-of-pocket cost amount and will let you know when you have reached that amount. If you or another party on your behalf have purchased drugs outside of our plan benefit, you will be responsible for submitting appropriate documentation of such purchases to us. In addition, every month you purchase covered prescription drugs through us, you will get an Explanation of Benefits that shows your out-of-pocket cost amount to date.

Explanation of Benefits

What is the Explanation of Benefits?

The Explanation of Benefits is a document you will get each month you use your prescription drug coverage. It will tell you the total amount you have spent on your prescription drugs and the total amount we have paid for your drugs. You will get your Explanation of Benefits in the mail each month that you use the benefits provided by us. You will not get an Explanation of Benefits if you do not use any benefits that month.

What information is included in the Explanation of Benefits?

Your Explanation of Benefits will contain the following information:

- A list of prescriptions you filled during the month, as well as the amount paid for each prescription;
- Information about how to request an exception and appeal our coverage decisions;
- A description of changes to the formulary affecting the prescriptions you filled that will occur at least 60 days in the future;
- A summary of your coverage this year, including information about:
    - **Annual Deductible** -the amount you pay, and/or others, before you start receiving prescription coverage.
    - **Amount Paid For Prescriptions** -the amounts paid that count towards your out-of-pocket maximum.
    - **Total Out-Of-Pocket Costs** -The total amount you and/or others have spent on prescription drugs that count towards your maximum out-of-pocket. This total includes the amounts spent for your co-payments and co-insurance. (This amount does not include payments made by PEIA, another insurance plan or policy, government funded health program or other excluded parties.)

What should you do if you did not get an Explanation of Benefits or if you wish to request one?

An Explanation of Benefits is also available upon request. To get a copy, please contact Customer Service.

How does your prescription drug coverage work if you go to a hospital or skilled nursing facility?

If you are admitted to a hospital for a Medicare-covered stay, our Plan's medical benefit should generally cover the cost of your prescription drugs while you are in the hospital. Once you are released from the hospital, we will cover your prescription drugs as long as all coverage requirements are met (such as the drugs being on our formulary, filled at a network pharmacy, etc.)and they are not covered by our Plan's medical benefit,. We will also cover your prescription drugs if they are approved under the coverage determination, exceptions, or appeals process.

If you are admitted to a skilled nursing facility for a Medicare-covered stay, after our Plan's medical benefit stops paying for your prescription drug costs, we will cover your prescriptions as long as the drug meets all of our coverage requirements (including the requirement that the skilled nursing facility pharmacy be in our pharmacy network, unless you meet standards for out-of-network care, and that the drug would not otherwise be covered by our Plan's medical benefit). Please see Section 13 of this document for more information about leaving this Plan and joining a new Medicare Prescription Drug Plan.

Section 7 Hospital care, skilled nursing facility care, and other services

This section gives additional information about some of the covered services that are listed in the Benefits Chart in Section 4.

Hospital care

If you need hospital care, you can obtain care from any hospital in the U.S. that is eligible to be paid by Medicare and willing to accept the plan's terms and conditions. Covered services are listed in the Benefits Chart in Section 4 under the heading "Inpatient Hospital Care." We use "hospital" to mean a facility that is certified by the Medicare program and licensed by the state to provide inpatient, outpatient, diagnostic, and therapeutic services. The term "hospital" does not include facilities that mainly provide custodial care (such as convalescent nursing homes or rest homes). By "custodial care," we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.

Skilled nursing facility care (SNF care)

Covered services are listed in the Benefits Chart in Section 4 under the heading "Skilled nursing facility care." The purpose of this subsection is to tell you more about some rules that apply to your covered services.

A skilled nursing facility is **a place that provides skilled nursing or skilled rehabilitation services.** It can be a separate facility, or part of a hospital or other health care facility. A **S**killed **N**ursing **F**acility is called a "SNF" for short. The term "skilled nursing facility" does not include places that mainly provide custodial care, such as convalescent nursing homes or rest homes. (By "custodial care," we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.)

What is skilled nursing facility care?

"Skilled nursing facility care" means a level of care ordered by a physician that must be given or supervised by licensed health care professionals. It can be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services include physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment, such as how to use a walker or get in and out of a wheel chair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to do usual daily activities, such as eating and dressing by yourself.

To be covered, the care you get in a SNF must meet certain requirements

To be covered, you must need daily skilled nursing or skilled rehabilitation care, or both. If you do not need daily skilled care, other arrangements for care would need to be made. Note that medical services and other skilled care will still be covered when you start needing less than daily skilled care in the SNF. If you have any question whether the Plan will pay for a service, including inpatient hospital services, you have the right under law to have a written / binding advance coverage determination made for the service. Call Customer Service at the number on the cover of this booklet and tell us you would like a decision if the service will be covered.

Stays that provide custodial care only are not covered

"Custodial care" is care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who do not have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial care is not covered by the Plan unless it is provided as other care you are getting *in addition to* daily skilled nursing care and/or skilled rehabilitation services.

There are benefit period limitations on coverage of skilled nursing facility care

Inpatient skilled nursing facility coverage is limited to 100 days each benefit period. A "**benefit period**" begins on the first day you go to a Medicare-covered inpatient hospital or a SNF. The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

Please note that after your SNF day limits are used up, Original Medicare will still pay for covered physician services and other medical services will still be covered. These services are listed in the Benefits Chart in Section 4 under the heading, "Inpatient services (when the hospital or SNF days are no longer covered)."

Please also note that if you are receiving SNF services out of plan, and paying Original Medicare out-of-pocket amounts for the SNF services, you will have to pay Original Medicare out-of-pocket amounts for other services you get while you are in the SNF.

What happens if you join or drop out of our Plan during a SNF stay?

If you either join or leave our Plan during a SNF stay, please call Customer Service at the telephone number on the cover of this booklet. Customer Service can explain how your services are covered for this stay, and what you owe, if anything, for the periods of your stay when you were and were not a Plan member.

Home health agency care

Home health care is skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Section 4 under the heading "Home health care." If you need home health care services, we will cover these services for you if the requirements described below are met.

What are the requirements for getting home health agency services?

To get home health agency care benefits, you must meet all of these conditions:

1. You must be **home-bound**. This means that you are normally unable to leave your home and that leaving home is a major effort. When you leave home, it must be to get medical treatment or be infrequent, for a short time. You may attend religious services. You can also get care in an adult day care program that is licensed or certified by a state or accredited to furnish adult day care services in a state.

   Occasional absences from the home for non-medical purposes, such as an occasional trip to the barber or a walk around the block or a drive, would not mean that you are not homebound if the absences are infrequent or are of relatively short duration. The absences cannot indicate that you have the capacity to obtain the health care provided outside of your home.

   Generally speaking, you will be considered to be homebound if you have a condition due to an illness or injury that restricts your ability to leave your home except with the aid of supportive devices or if leaving home is medically contraindicated. "Supportive devices" include crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person.

2. Your doctor must decide that you need medical care in your home, and must make a plan for your care at home. Your **plan of care** describes the services you need, how often you need them, and what type of health care worker should give you these services.

3. The home health agency caring for you must be approved by the Medicare program.

4. You must need *at least one* of the following types of skilled care:

   - Skilled nursing care on an "intermittent" (not full time) basis. Generally, this means that you must need at least one skilled nursing visit every 60 days and not require daily skilled nursing care for more than 21 days. Skilled nursing care includes services that can only be performed by or under the supervision of a licensed nurse.
   - Physical therapy, which includes exercise to regain movement and strength to an area of the body, and training on how to use special equipment or do daily activities such as how to use a walker or get in and out of a wheel chair or bathtub.
   - Speech therapy, which includes exercise to regain and strengthen speech skills or to treat a swallowing problem.

- Continuing occupational therapy, which helps you learn how to do usual daily activities by yourself. For example, you might learn new ways to eat or new ways to get dressed.

Home health care can include services from a home health aide, as long as you are <u>also</u> getting skilled care

As long as some qualifying skilled services are *also* included, the home health care you get can include services from a home health aide. A home health aide does not have a nursing license. The home health aide provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care such as bathing, using the toilet, dressing, or carrying out the prescribed exercises. The services from a home health aide must be part of the home care of your illness or injury, and they are not covered unless you are *also* getting a covered skilled service. Home health services do not include the costs of housekeepers, food service arrangements, or full-time nursing care at home.

What are "part time" and "intermittent" home health care services?

If you meet the requirements given above for getting covered home health services, you may be eligible for "part time" or "intermittent" skilled nursing services and home health aide services:

- **"Part-time" or "Intermittent"** means your skilled nursing and home health aide services combined total less than 8 hours per day and 35 or fewer hours each week.

<u>If you have any question whether the Plan will pay for a service, including inpatient hospital services, you have the right under law to have a written / binding advance coverage determination made for the service. Call Customer Service at the number on the cover of this booklet and tell us you would like a decision if the service will be covered.</u>

Hospice care for people who are terminally ill

"Hospice" is a special way of caring for people who are terminally ill, and for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients make the most of the last months of life by giving comfort and relief from pain. The focus is on care, not cure.

As a member of our Plan, you may receive care from any Medicare-certified hospice. Your doctor can help you arrange for your care in a hospice. If you are interested in using hospice services, you can call Customer Service at the number on the cover of this booklet to get a list of the Medicare-certified hospice providers in your area. ,

If you enroll in a Medicare-certified hospice, Original Medicare (rather than Advantra Freedom) pays the hospice for the hospice services you receive. Your hospice doctor can be a plan provider or a non-plan provider. If you choose to enroll in a Medicare-certified hospice, you will still be a Plan member and continue to get the rest of your care that is unrelated to your terminal condition through our Plan. If you use non-plan providers for your routine care, Original Medicare (rather than our Plan) will cover your care and you will have to pay Original Medicare out-of-pocket amounts.

The Medicare program has written a booklet about "Medicare Hospice Benefits." To get a free copy call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), which is the national Medicare help line, or visit the Medicare Web site at www.medicare.gov. Section 1 tells more about how to contact the Medicare program and about the Web site.

Organ transplants

If you need an organ transplant, we will arrange to have your case reviewed by one of the transplant centers that is approved by Medicare (some hospitals that perform transplants are approved by Medicare, and others are not). The Medicare-approved transplant center will decide whether you are a candidate for a transplant. When all requirements are met, the following types of transplants are covered: corneal, kidney, pancreas, liver, heart, lung, heart-lung, bone marrow, intestinal/multivisceral, and stem cell. Please be aware that the following transplants are covered only if they are performed in a Medicare-approved transplant center: heart, liver, lung, heart-lung, and intestinal/multivisceral transplants.

Participating in a clinical trial

A "clinical trial" is a way of testing new types of medical care, like how well a new cancer drug works. Clinical trials are one of the final stages of a research process to find better ways to prevent, diagnose, or treat diseases. The trials help doctors and researchers see if a new approach works and if it is safe.

Medicare pays for routine costs if you take part in a clinical trial that meets Medicare requirements. Routine costs include costs like room and board for a hospital stay that Medicare would pay for even if you were not in a trial, an operation to implant an item that is being tested, and items and services to treat side effects and complications arising from the new care. Generally, Medicare will not cover the costs of experimental care, such as the drugs or devices being tested in a clinical trial.

There are certain requirements for Medicare coverage of clinical trials. If you participate as a patient in a clinical trial that meets Medicare requirements, Original Medicare Plan (and not our Plan) pays the clinical trial doctors and other providers for the covered services you receive that are related to the clinical trial. When you are in a clinical trial, you may stay enrolled in our Plan and continue to get the rest of your care that is unrelated to the clinical trial through our Plan.

You will have to pay Original Medicare co-insurance for the services you receive when participating in a qualifying clinical trial. You do not have to pay the Original Medicare Part A or Part B deductibles, because you are enrolled in our Plan. For instance, you will be responsible for Part B co-insurance -- generally 20% of the Medicare-approved amount for most doctor services and most other outpatient services. However, there is no co-insurance for Medicare-covered clinical laboratory services related to the clinical trial. The Medicare program has written a booklet that includes information on Original Medicare co-insurance rules, called "Medicare & You." To get a free copy, call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov on the web.

You do *not* need to get a referral from a plan provider to join a clinical trial, and the clinical trial providers do *not* need to be plan providers. However, please be sure to **tell us before you start a clinical trial,** so that we can keep track of your health care services. When you tell us about starting a clinical trial, we can let you know what services you will get from clinical trial providers and your costs for those services.. The Medicare program has written a booklet about "Medicare and Clinical Trials." To get a free copy, call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov on the Web. Section 1 tells you more about how to contact the Medicare program and about Medicare's Web site.

Care in Religious Non-medical Health Care Institutions

Care in a Medicare-certified **R**eligious **N**on-medical **H**ealth **C**are **I**nstitution (RNHCI) is covered by our Plan under certain conditions. Covered services in a RNHCI are limited to non-religious aspects of care. To be eligible for covered services in a RNHCI, you must have a medical condition that would allow you to receive inpatient hospital care or extended care services. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of "non-excepted" medical treatment. ("Excepted" medical treatment is medical care or treatment that you receive involuntarily or that is required under federal, state, or local law. "Non-excepted" medical treatment is any other medical care or treatment.) You must also get authorization (approval) in advance from the Plan, or your stay in the RNHCI may not be covered.

Note: Medicare coverage limits apply. To verify coverage and your cost sharing responsibility in a religious non-medical health care institution, you or your provider should contact the Plan for an advance determination of coverage.

Section 8 What you must pay for your Medicare health plan coverage and for the care you receive

You are eligible to enroll in this coverage pursuant to our contract with PEIA to provide this coverage to PEIA's eligible retirees and their eligible spouses. PEIA determines who is an eligible retiree or eligible spouse of a retiree in accordance with its policies and procedures. In the event that (i) the contract between us and PEIA is terminated for any reason, or (ii) PEIA informs us that you are no longer an eligible retiree or eligible spouse of a retiree, your coverage under this plan will terminate as of the date the contract is terminated or you are no longer an eligible retiree or eligible dependent of a retiree, as applicable. Advantra Freedom and PEIA must provide 30 day notice prior to involuntary termination per CMS guidelines.

Paying the plan premium for your coverage as a member of our Plan

To be a member of the Plan, you must continue to pay your Medicare Part B premium. If you have to pay a Medicare Part A premium (most people do not), you must continue paying that premium to be a member. You also have Plan premiums that you must pay through PEIA.

What happens if you don't pay your Plan premiums, co-payments or coinsurance or don't pay on time?

If your Plan premiums are past due or you have not been paying your co-payments or co-insurance, the Plan may disenroll you and will tell you in writing. Disenrolling you ends your membership in the plan. We will tell you in writing of your disenrollment at least 30 days before you are disenrolled. You will then have Original Medicare coverage (Section 12 explains about disenrollment and Original Medicare coverage).

Paying your share of the cost when you get covered services

What are "co-payments" and "co-insurance"?

A **"co-payment"** is a payment you make for your share of the cost of certain covered services or drugs you receive. A co-payment is **a set amount per service or drug** (such as paying $50 for an emergency room visit) that you pay when you get the service or drug. The Benefits Chart in Section 4 gives your co-payments for covered services and drugs.

"Co-insurance" is a payment you make for your share of the cost of certain covered services you receive. Co-insurance is a percentage of the cost of the service (such as

paying 20% for radiation therapy). The Benefits Chart in Section 4 gives your co-insurance for covered services.

You must pay the full cost of services that are not covered

If you received services from a certified provider that does not have an actual written contract with Advantra Freedom, but informed this provider that you are enrolled in Advantra Freedom -- for example, you showed the provider your ID card -- then this provider is deemed to have a contract with the Plan and is bound by the plan's terms and conditions of payments. A provider is deemed to have a contract even if they did not verbally acknowledge that they were accepting the Plan's terms and conditions of payments, and even if they did not even look up (but had access to) the details of these terms and conditions of payments.

However, if you receive services from a certified provider that does not have an actual written contract with Advantra Freedom and this provider was not informed, and did not know, that you are enrolled in Advantra Freedom, then you must pay Original Medicare out-of-pocket amounts if you receive Medicare-covered services that are not for the care of a medical emergency, urgently needed care, or services that are found upon appeal to be services that we should have paid or covered. (Sections 2 and 3 explain about using plan providers and the exceptions that apply.)

If you have any question whether Advantra Freedom will pay for a service, including inpatient hospital services, you have the right under law to have a written / binding advance coverage determination made for the service. Call Customer Service at the number on the cover of the booklet and tell us you would like a decision if the service will be covered.

For covered services that have a benefit limitation, **you must pay the full cost of any services you get after you have used up your benefit for that type of covered service**. Paying for costs once a benefit limit has been reached will NOT count towards your out-of-pocket maximum. You can call Customer Service when you want to know how much of your benefit limit you have already used.

Please keep us up-to-date on any other health insurance coverage you have

Using *all* of your insurance coverage

If you have other health insurance coverage or prescription drug coverage besides our Plan, it is important to use your other coverage *in combination with* your coverage as a member of our Plan to pay for the health care or prescription drug expenses. This is called “coordination of benefits” because it involves *coordinating* all of the health or drug *benefits* that are available to you. Using all of the coverage you have helps keep the cost of health care more affordable for everyone.

Let us know if you have additional insurance

You must tell us if you have any other health insurance coverage or prescription drug coverage besides our Plan, and let us know whenever there are any *changes* in your additional insurance coverage. The types of additional insurance coverage you might have include the following:

- Coverage that you have from an employer's group health insurance for *employees* or *retirees*, either through yourself or your spouse.
- Coverage that you have under workers' compensation because of a job-related illness or injury, or under the Federal Black Lung Program.
- Coverage you have for an accident where no-fault insurance or liability insurance is involved.
- Coverage you have through Medicaid.
- Coverage you have through the "TRICARE for Life" program (veteran's benefits).
- Coverage you have for dental insurance or prescription drugs.
- "Continuation coverage" that you have through COBRA (COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions).

Who pays first when you have additional insurance?

How we coordinate your benefits as a member of our Plan with your benefits from other insurance depends on your situation. If you have other coverage, you will often get your care as usual through our Plan, and the other insurance you have will simply help pay for the care you receive. In other situations, such as for benefits that are not covered by our Plan, you may get your care outside of our Plan.

The insurance company that pays its share of your bills *first* is called the "**primary payer**." Then the other company or companies that are involved—called the "**secondary payers**"— each pays their share of what is left of your bills. Often your other insurance company will settle its share of payment directly with us and you will not have to be involved. However, if payment owed to us is sent directly to you, you are required under Medicare law to give this payment to us. When you have additional health insurance, **whether we pay first or second—or at all—depends on what type or types of additional insurance you have and the rules that apply to your situation**. Many of these rules are set by Medicare. Some of them take into account whether you have a disability or have End-Stage Renal Disease (permanent kidney failure), or how many employees are covered by an employer's group insurance.

If you have additional health insurance, please call Customer Service at the phone number on the cover of this booklet to find out which rules apply to your situation, and how payment will be handled. Also, the Medicare program has written a booklet with general information about what happens when people with Medicare have additional insurance. It's called "Medicare and Other Health Benefits: Your Guide to Who Pays

First." You can get a copy by calling 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), or by visiting the www.medicare.gov Web site.

For Bills: What do we pay? What does the Plan Pay?

You should never pay the provider more than the cost-sharing allowed by our Plan. You should ask your provider to bill us for the rest of his or her fee and we will pay him or her according to our Plan terms and conditions of payment. If the provider asks you to pay the remainder of the bill and have you directly reimbursed from the Plan, tell him or her that you only have to pay the cost-sharing amount. Your enrollment card in our Plan will indicate how the provider can contact us for information on our terms and conditions of payment. If the provider wants further information on payment for covered services, please have them contact us at Customer Service, Coventry Health Care, Inc., PO Box 7154, London, KY, 40742-7154.

If you receive a bill for the services, you may send the bill to us for payment. However, if you have already paid for the covered services we will reimburse you for our share of the cost. We will pay your doctor for our share of the bill and will let you know if you must pay any cost-sharing.

Section 9 Your rights and responsibilities as a Member of our Plan

Introduction about your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this Section, we explain your Medicare rights and protections as a member of our Plan and we explain what you can do if you think you are being treated unfairly or your rights are not being respected. If you want to receive Medicare publications on your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, or visit www.medicare.gov on the Web to view or download the publication "Your Medicare Rights & Protections." Under "Search Tools," select "find a Medicare Publication".

If you have any question whether our Plan will pay for a service, including inpatient hospital services, you have the right under law to have a written / binding advance coverage determination made for the service. Call Customer Service at the phone number on the cover of this booklet and tell us you would like a decision if the service will be covered.

Your right to be treated with fairness and respect

You have the right to be treated with dignity, respect, and fairness at all times. Our Plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin race or color, age, religion, national origin, or any mental or physical disability. If you need help with communication, such as help from a language interpreter, please call Customer Service at the number on the cover of this booklet. Customer Service can also help if you need to file a complaint about access (such as wheelchair access). You may also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or, call the Office for Civil Rights in West Virginia by referencing the chart below.

Office for Civil Rights

Region	Address
Region III Philadelphia	(Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia) Office for Civil Rights U.S. Department of Health and Human Services 150 S. Independence Mall West Suite 372 Philadelphia, PA 19106-3499

Your right to the privacy of your medical records and personal health information

There are federal and state laws that protect the privacy of your medical records and personal health information. We protect your personal health information under these laws. Any personal information that you give us when you enroll in this Plan is protected. We will make sure that unauthorized people do not see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who is not providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. For example, you have the right to look at your medical records held at the Plan, and to get a copy of the records (there may be a fee charged for making copies). You also have the right to ask your providers to make additions or corrections to your medical records (if you ask your providers to do this, they will review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call Customer Service at the phone number on the cover of this booklet.

Your right to see plan providers, get covered services, and get prescription drugs filled within a reasonable period of time

As explained in this booklet, you will get most or all of your care from licensed providers who have agreed to treat you under our Plan terms and conditions of payment. You have the right to seek care from any provider in the U.S. who is eligible to be paid by Medicare and accepts our Plan's terms and conditions of payment. You also have the right to timely access to your prescriptions at any network pharmacy. "Timely access" means that you can get appointments and services within a reasonable amount of time. Section 2 explains how to use plan providers to get the care and services you need. Section 3 explains your rights to get care for a medical emergency and urgently needed care.

Your right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our Plan. This includes the right

to know about the different Medication Management Treatment Programs in which you may participate. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment and be given the choice of refusing experimental treatments.

You have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of refusing treatment.

Your right to use advance directives (such as a living will or a power of attorney)

You have the right to ask someone, such as a family member or friend, to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone you trust the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called "**advance directives.**" There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you decide that you want to have an advance directive, there are several ways to get this type of legal form. You can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare, such as your SHIP (which stands for State Health Insurance Assistance Program). Section 1 of this booklet tells how to contact your SHIP. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you cannot. You may want to give copies to close friends or family members as well.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have *not* signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is *your choice* whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you *have* signed an advance directive, and you believe that a doctor or hospital has not followed the instructions in it, you may file a complaint with

the West Virginia State agency below. You may contact Customer Service at the number on the cover of this booklet for information on State Health Departments in other states.

State Health Department:

State	Address	Phone
West Virginia	West Virginia Department of Health and Human Resources, Bureau for Public Health Room 702 350 Capitol Street Charleston, WV 25326-3712 http://www.wvdhhr.org/bph/index.htm	(304) 558-2971 Fax: (304)558-1035

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. "Appeals" and "grievances" are the two different types of complaints you can make. The complaint is called an appeal or grievance depending on the situation. Appeals and grievances that involve your Medicare health benefits under our Plan are discussed in Sections 10 and 11. Appeals and grievances that involve the Plan drug benefit are discussed in Sections 10 and 12.

Your right to get information about our Plan drugs, health care coverage and costs

This booklet tells you what medical services are covered for you as a Plan member and what you have to pay.

If you need more information, please call Customer Service at the number on the cover of this booklet. You have the right to an explanation from us about any bills you may get for services not covered by our Plan. We must tell you in writing why we will not pay for or allow you to get a service, and how you may file an appeal to ask us to change this decision. See Sections 10 and 11 for more information about filing an appeal.

Your right to get information about our Plan, plan providers, and your drug coverage and costs

You have the right to get information from us about our Plan. This includes information about our financial condition, our network pharmacies, and how our Plan compares to other health plans. You have the right to find out from us how we pay our doctors. To get any of this information, call Customer Service at the phone number listed on the cover. You have the right under law to have a written/binding advance coverage determination made for the service.

How to get more information about your rights

If you have questions or concerns about your rights and protections, please call Customer Service at the number on the cover of this booklet. You can also get free help and information from your State Health Insurance Assistance Program, or SHIP (Section 1 tells how to contact the SHIP in your state). In addition, the Medicare program has written a booklet called "Your Medicare Rights and Protections." To get a free copy, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, you can visit www.medicare.gov on the Web to order this booklet or print it directly from your computer.

What can you do if you think you have been treated unfairly or your rights are not being respected?

If you think you have been treated unfairly or your rights have not been respected, what you should do depends on your situation.

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, please let us know. Or, you can call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697
- For any other kind of concern or problem related to your Medicare rights and protections described in this section, you can call Customer Service at the number on the cover of this booklet. You can also get help from your State Health Insurance Assistance Program, or SHIP (Section 1 tells how to contact the SHIP in your state).

Your responsibilities as a member of our Plan

Along with the rights you have as a member of Advantra Freedom, you also have some responsibilities. Your responsibilities include the following:

- To get familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet and other information we give you to learn about your coverage, what you have to pay, and the rules you need to follow. Please call Customer Service at the phone number on the cover of this booklet if you have any questions.
- Notify providers when seeking care (unless it is an emergency) that you are enrolled in our Plan, which is a Medicare private fee-for-service plan, and you must present your Plan enrollment card to the provider.
- To give your doctor and other providers the information they need to care for you, to follow the treatment plans and instructions that you and your doctors agree upon, and be sure to ask your doctors and other providers if you have any questions and have them explain your treatment in a way you can understand.
- To act in a way that supports the care given to other patients and helps the smooth running of your doctor's office, hospitals, and other offices.

- To pay your plan premiums, co-insurance and any co-payments you owe for your covered services. You must also meet your other financial responsibilities that are described in Section 8 of this booklet.
- To let us know if you have any questions, concerns, problems, or suggestions. If you do, please call Customer Service at the phone number on the cover of this booklet.

Section 10 How to file a grievance

What is a Grievance?

A grievance is different from a request for an organization determination, a request for a coverage determination, or a request for an appeal as described in Section 11 and Section 12 of this manual because grievances do not involve problems related to approving or paying for care or Part D benefits, problems about being discharged from the hospital too soon, and problems about coverage for Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) services ending too soon.

For problems about coverage or payment for care, problems about being discharged from the hospital too soon, and problems about coverage for SNF, HHA, or CORF services ending too soon, you must follow the rules outlined in Section 11.

If you have a problem about our failure to cover or pay for a Part D prescription drug, you must follow the rules outlined in Section 12.

What types of problems might lead to you filing a grievance?

- Problems with the quality of the medical care you receive, including quality of care during a hospital stay.
- If you feel that you are being encouraged to leave (disenroll from) the Plan.
- Problems with the service you receive from Customer Service.
- Problems with how long you have to wait on the phone, in the waiting room, in a network pharmacy, or in the exam room.
- Problems with getting appointments when you need them, or waiting too long for an appointment.
- Disrespectful or rude behavior by doctors, nurses, receptionists, network pharmacists, or other staff.
- Cleanliness or condition of doctor's offices, clinics, network pharmacies, or hospitals.
- If you disagree with our decision not to give you a "fast" decision or a "fast" appeal.
- You believe our notices and other written materials are difficult to understand.
- We do not give you a decision within the required timeframe.
- We do not forward your case to the independent review organization if we do not give you a decision within the required timeframe.
- We do not give you required notices.

If you have one of these types of problems and want to make a complaint, it is called "filing a grievance." In certain cases, you have the right to ask for a "fast grievance," meaning your grievance will be decided within 24 hours. We discuss these fast grievances in more detail in Section 11 and Section 12.

Filing a grievance with our Plan

If you have a complaint, we encourage you to first call Customer Service at the number on the cover of this booklet. We will try to resolve any complaint that you might have over the phone. If you request a written response to your phone complaint, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this the Plan Grievance Procedure**. You should submit complaints orally or in writing to the Plan Customer Service Department at the number on the cover of this booklet or the address listed below. A Customer Service Representative will review and research to resolve your complaint in a timely and equitable manner. You will be informed of the resolution in writing within 30 days. An exception to the 30-day resolution process is the expedited or fast grievance process in which Plan will respond to your complaint within 24 hours of you contacting us, if this issue is in regards to our decision not to give you a fast appeal or if we take an extension on our initial decision or appeal.

Send your written grievance within 60 days from the date of the event:

Advantra Freedom

Attn: Appeals Department

500 Virginia Street East, Suite 400

Charleston, WV 25301

We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the timeframe by up to 14 days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

For quality of care problems, you may also complain to the Quality Improvement Organization (QIO)

You may complain about the quality of care received under Medicare, including care during a hospital stay. You may complain to us using the grievance process, to an independent review organization called the Quality Improvement Organization QIO, or both. If you file with the QIO, we must help the QIO resolve the complaint. See Section 1 for more information about the QIO.

How to file a quality of care complaint with the QIO

You must write to the QIO to file a quality of care complaint. You may file your complaint with the QIO at any time. See Section 1 for more information about how to file a quality of care complaint with the QIO.

Section 11 What to Do if you have Complaints about Your Part C Medical Services and Benefits

Introduction

This section gives the rules for making complaints about Part C services and payments in different types of situations. Part C is your medical services and benefits. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your medical care as a plan member. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from Advantra Freedom or penalized in any way if you make a complaint.

Please refer to Original Medicare in your 2008 *Medicare and You Handbook* for additional guidance on your appeal rights under Original Medicare. If you do not have a *Medicare & You Handbook,* please call *1-800 Medicare* to get a copy.

How to make complaints in different situations

This section tells you how to complain about services or payment in each of the following situations:

Part 1. Complaints about what benefit or service we will approve or what we will pay for.

Part 2. Complaints if you think you are asked to leave the hospital too soon.

Part 3. Complaints if you think your skilled nursing facility (SNF), home health (HHA) or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

If you want to make a complaint about any situation not listed above, you may file a **grievance**. **For more information about grievances, see Section 10.**

PART 1. COMPLAINTS ABOUT WHAT BENEFIT OR SERVICE THE PLAN WILL APPROVE OR WHAT THE PLAN WILL PAY FOR

What are "complaints about your services or payment for your care?"

- If you are not getting the care you want, and you believe that this care is covered by the Plan.
- If we will not approve the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by the Plan.
- If you are being told that a treatment or service you have been getting will be reduced or stopped, and you believe that this could harm your health.
- If you have received care that you believe should be covered by the Plan, but we have refused to pay for this care because we say it is not medically necessary or is not a Plan benefit.

What is an organization determination?

An organization determination is our initial decision about whether we will provide the medical care or service you request, or pay for a service you have already received.

If our initial decision is to deny your request, you can **appeal** the decision by going to Appeal Level 1 (see below). You may also appeal if we fail to make a timely initial decision on your request.

When we make an "initial decision," we are giving our interpretation of how the benefits and services that are covered for members of the Plan apply to your specific situation. This booklet and any amendments you may receive describe the benefits and services covered by the Plan, including any limitations that may apply to these services. This booklet also lists exclusions (services that are "not covered" by the Plan).

Who may ask for an "initial decision" about your medical care or payment?

Depending on the situation, your doctor or other medical provider may ask us whether we will authorize the treatment. Otherwise, you can ask us for an initial decision yourself, or you can name (appoint) someone to do it for you. The person you name would be your representative. You can name a relative, friend, advocate, doctor, or someone else to act for you. If you want someone to act for you, then you and the person you want to act for you must sign and date a statement that gives this person legal permission to act as your representative. This statement must be sent to us at Advantra Freedom, Coventry Health Care, Inc., PO Box 7154, London, KY 40742-7154. You can call us at the number on the cover of this booklet to learn how to name your representative.

You also have the right to have an attorney ask for an initial decision on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar

association or other referral service. There are also groups that will give you free legal services if you qualify.

Do you have a request for medical care that needs to be decided more quickly than the standard time frame?

A decision about whether we will cover medical care can be a "standard decision" that is made within the standard time frame (typically within 14 days), or it can be a "fast decision" that is made more quickly (typically within 72 hours). A fast decision is sometimes called an "expedited organization determination."

You may ask for a fast decision **only** if you or any doctor believe that waiting for a standard decision could seriously harm your health or your ability to function.

Asking for a standard decision

To ask for a standard decision about providing medical care or payment for care, you or your representative should mail or deliver a request in writing to the following address: Advantra Freedom, Coventry Health Care, Inc., PO Box 7154, London, KY 40742-7154..

Asking for a fast decision

You, any doctor, or your representative may ask us to give a "fast" decision (rather than a "standard" decision) about medical care by calling us at 1-877-337-4178 (for TTY, call 1-866-386-2335 . Or, you can deliver a written request to Advantra Freedom, Coventry Health Care, Inc., 8320 Ward Parkway, Kansas City, MO 64114, or fax it to 1-866-415-2821. Please ensure you mark your request as Fast Decision. Be sure to ask for a "fast" or "72-hour" review.

If **any** doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will give you a fast decision.

If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter informing you that if you get a doctor's support for a "fast" decision, we will automatically give you a fast decision. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review. It will also tell you about your right to ask for a "fast grievance." If we deny your request for a fast decision, we will give you a standard decision. For more information about grievances, see Section 10.

What happens next when you request an initial decision?

1. **For a decision about payment for care you already received.**

   We have thirty (30) days to make a decision after we have received your request. However, if we need more information, we can take up to thirty (30) more days. You will be told in writing if we extend the timeframe for making a decision. If we

do not approve your request for payment, we must tell you why, and tell you how you can appeal this decision. If you have not received an answer from us within sixty (60) days of your request, you can **appeal** this decision. (An appeal is also called a "reconsideration.")

2. **For a <u>standard</u> initial decision about medical care.**

   We have fourteen (14) days to make a decision after we have received your request. However, we can take up to fourteen (14)more days if you request the additional time, or if we need more time to gather information (such as medical records) that may benefit you. If we take additional days, we will notify you in writing. If you believe that we should not take additional days, you can make a specific type of complaint called a "fast grievance" (see Section 10).

   If we do not approve your request, we must explain why in writing, and tell you of your right to appeal our decision.

   If you have not received an answer from us within fourteen (14) days of your request (or by the end of any extended time period), you have the right to appeal.

3. **For a <u>fast</u> initial decision about medical care.**

   If you receive a "fast" decision, we will give you our decision about your medical care within 72 hours after you or your doctor ask for it – sooner if your health requires. However, we can take up to fourteen (14) more days if we find that some information is missing that may benefit you, or if you need more time to prepare for this review. If you believe that we should not take any additional days, you can file a fast grievance.

   We will call you as soon as we make the decision. If we deny any part of your request, we will send you a letter that explains the decision within three 3 days of calling you. If we do not tell you about our decision within 72 hours (or by the end of any extended time period), this is the sam as denying your request and you have the right to appeal. If we deny your request for a fast decision, you may file a fast grievance.

Appeal Level 1: If we deny any part of your request for a service or payment of a service, you may ask us to reconsider our decision. This is called an "appeal" or a "request for reconsideration."

Please call us at the number on the cover of this booklet if you need help in filing your appeal. We give the request to different people than those who were involved in making the initial decision. This helps ensure that we will give your request a fresh look.

If your appeal concerns a decision we made about authorizing medical care, then you and/or your doctor will first need to decide whether you need a "fast" appeal. The procedures for deciding on a "standard" or a "fast" *appeal* are the same as those described for a "standard" or "fast" *initial decision*. Fast Decisions are sent to our

pharmacy area, but Fast appeals are sent to our appeals and grievance area noted below.

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to the issue, or you may want to get the doctor's records or the doctor's opinion to help support your request. You may need to give the doctor a written request to get information.

You can give us your additional information in any of the following ways:

- In writing, to Advantra Freedom, Attn: Appeals Department, 500 Virginia Street East, Suite 400, Charleston, WV 25301.
- By fax,1-800-535-4047.
- By telephone – if it is a "fast appeal" – at 1-866-275-9280 Monday – Friday 8 a.m. – 5 p.m. Eastern Time, hearing impaired members should call our TDD number at 1-866-386-2335.
- You also have the right to ask us for a copy of information regarding your appeal. You can call us at the number on the cover of this booklet or write to, Advantra Freedom, Attn: Appeals Department, 500 Virginia Street East, Suite 400, Charleston, WV 25301.

How do you file your appeal of the initial decision?

The rules about who may file an appeal are the same as the rules about who may ask for an initial decision. Follow the instructions under "Who may ask for an 'initial decision' about medical care or payment?" However, providers who do not have a contract with the Plan must sign a "waiver of payment" statement that says that they will not ask you to pay for the medical service under review, regardless of the outcome of the appeal.

How soon must you file your appeal?

You must file your appeal within sixty (60) days after we notify you of the initial decision. We can give you more time if you have a good reason for missing the deadline. To file your appeal you can call us at the telephone number on the cover of this booklet or send the appeal to us in writing at Advantra Freedom, Attn: Appeals Department, 500 Virginia Street East, Suite 400, Charleston, WV 25301.

What if you want a "fast" appeal?

The rules about asking for a "fast" appeal are the same as the rules about asking for a "fast" initial decision. Fast Decisions are sent to our pharmacy area, but Fast appeals are sent to our appeals and grievance area noted above.

How soon must we decide on your appeal?

1. **For a decision about payment for care you already received.**

   After we receive your appeal, we have sixty (60) days to make a decision. If we do not decide within sixty (60) days, your appeal *automatically* goes to Appeal Level 2.

2. **For a standard decision about medical care.**

   After we receive your appeal, we have up to thirty (30) days to make a decision, but will make it sooner if your health condition requires. However, if you request more time, or if we find that some helpful information is missing, we can take up to fourteen (14) more days to make our decision. If we do not tell you our decision within thirty (30) days (or by the end of the extended time period), your request will *automatically* go to Appeal Level 2.

3. **For a fast decision about medical care.**

   After we receive your appeal, we have up to 72 hours to make a decision, but will make it sooner if your health requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more days to make our decision. If we do not tell you our decision within 72 hours (or by the end of the extended time period), your request will *automatically* go to Appeal Level 2.

What happens next if we decide completely in your favor?

1. **For a decision about payment for care you already received.**

   We must pay within sixty (60) calendar days of the day we received your appreal request for us to reconsider our initial decision.

2. **For a standard decision about medical care.**

   We must authorize or provide you with the care you have asked for no later than thiry (30) days after we received your appeal. If we extended the time needed to decide your appeal, we will authorize or provide your medical care when we make our decision.

3. **For a fast decision about medical care.**

   We must authorize or provide you with the care you have asked for within 72 hours of receiving your appeal – or sooner, if your health requires it. If we extended the time needed to decide your appeal, we will authorize or provide your medical care at the time we make our decision.

Appeal Level 2: If we deny any part of your Level 1 appeal, your appeal will automatically be reviewed by a government-contracted independent review organization

If we deny any part of your appeal, your appeal *automatically* goes on to Appeal Level 2 where an independent review organization that has a contract with CMS (**C**enters for **M**edicare & Medicaid **S**ervices), the government agency that runs the Medicare program, and is not part of the Plan, will review your appeal. We will tell you in writing that your appeal has been sent to this organization for review. How quickly we must forward your appeal to the organization depends on the type of appeal:

1. **For a decision about payment for care you already received.**

   We must send all the information about your appeal to the independent review organization within 60 days from the date we received your Level 1 appeal.

2. **For a standard decision about medical care.**

   We must send all of the information about your appeal to the independent review organization as quickly as your health requires, but no later than 30 days after we received your Level 1 appeal.

3. **For a fast decision about medical care.**

   We must send all of the information about your appeal to the independent review organization within 24 hours of our decision.

We will send the independent review organization a copy of your case file. You also have the right to get a copy of your case file from us that we sent to this independent review organization.

How soon must the independent review organization decide?

1. *For an appeal about payment for care,* the independent review organization has up to sixty (60) days to make a decision.
2. *For a standard appeal about medical care,* the independent review organization has up to thirty (30) days to make a decision. However, it can take up to fourteen (14) more days if more information is needed and the extension will benefit you.
3. For a *fast* appeal about *medical care*, the independent review organization has up to 72 hours to make a decision. However, it can take up to fourteen (14) more days if more information is needed and the extension will benefit you

If the independent review organization decides completely in your favor:

The independent review organization will tell you in writing about its decision and the reasons for it.

1. **For an appeal about payment for care,**

   We must pay within thirty (30) days after receiving the decision.

2. **For a <u>standard</u> appeal about <u>medical care</u>,**

   We must *authorize* the care you have asked for within 72 hours after receiving notice of the decision, or *provide* the care no later than fourteen (14) days after receiving the decision.

3. **For a <u>fast</u> appeal about <u>medical care</u>,**

   We must authorize or provide you with the care you have asked for within 72 hours of receiving the decision.

Appeal Level 3: If the organization that reviews your case in Appeal Level 2 does not rule completely in your favor, you may ask for a review by an <u>Administrative Law Judge</u>

You must make a request for review by an Administrative Law Judge in writing within 60 days after the date you were notified of the decision made at Appeal Level 2. The deadline may be extended for good cause. You must send your written request to the ALJ Field Office that is listed in the decision you receive from the independent review organization. The Administrative Law Judge will not review the appeal if the dollar value of the medical care does not meet the minimum requirement provided in the independent review organization's decision. If the dollar value is less than the minimum requirement, you may not appeal any further. During this review, you may present evidence, review the record, and be represented by a lawyer.

How soon does the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

If the Judge decides in your favor

We must pay for, authorize, or provide the service you have asked for within sixty (60) days from the date we receive notice of the decision. We have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4).

If the Judge rules against you

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Administrative Law Judge will tell you how to request this review.

Appeal Level 4: Your case may be reviewed by the Medicare Appeals Council

This Council will first decide whether to review your case

The Medicare Appeals Council does not review every case it receives. If they decide not to review your case, then either you or we may request a review by a Federal Court

Judge (Appeal Level 5). The Medicare Appeals Council will send a written notice informing you of any action it has on your request. The notice will tell you how to request a review by a Federal Court Judge.

How soon will the Council make a decision?

If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

If the Council decides in your favor

We must pay for, authorize, or provide the medical service you have asked for within 60 days from the date we receive notice of the decision. However, we have the right to appeal this decision by asking a Federal Court Judge to review the case (Appeal Level 5), so long as the dollar value of the care you asked for meets the minimum requirement provided in the Medicare Appeals Council's decision. If the dollar value is less than the minimum requirement, the Council's decision is final.

If the Council decides against you

If the amount involved meets the minimum requirement provided in the Medicare Appeals Council's decision, you or we have the right to continue your appeal by asking a Federal Court Judge to review the case (Appeal Level 5). If the value is less than the minimum requirement, the Council's decision is final and you may not take the appeal any further.

Appeal Level 5: Your case may go to a Federal Court

In order to request judicial review of your case, you must file a civil action in a United States district court. The letter you get from the Medicare Appeals Council in Appeal Level 4 will tell you how to request this review. The Federal Court Judge will first decide whether to review your case.

Your appeal will not be reviewed by a Federal Court if the dollar value of the care you asked for does not meet the minimum requirement provided in the Medicare Appeals Council's decision.

How soon will the judge make a decision?

The Federal judiciary controls the timing of any decision. The Judge's decision is final and you may not take the appeal any further.

PART 2. COMPLAINTS (APPEALS) IF YOU THINK YOU ARE BEING DISCHARGED FROM THE HOSPITAL TOO SOON

When you are hospitalized, you have the right to get all the hospital care covered by the Plan that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your "discharge date") is based on when your stay in the hospital is no longer medically necessary. This part of Section 11 explains what to do if you believe that you are being discharged too soon.

Information you should receive during your hospital stay

When you are admitted to the hospital, someone at the hospital should give you a notice called the *Important Message from Medicare*. This notice explains:

- Your right to get all medically necessary hospital services covered.
- Your right to be involved in any decisions that the hospital, your doctor, or anyone else makes about your hospital services and who will pay for them.
- Your right to get services you need after you leave the hospital.
- Your right to appeal a discharge decision.

You (or your representative) may be asked to sign and date this document to show that you received the notice. Signing the notice does not mean that you agree that you are ready to leave the hospital – it only means that you received the notice. If you do not get the notice after you have said that you think you are being discharged too soon, ask for it immediately.

Review of your hospital discharge by the Quality Improvement Organization

If you think that you are being discharged too soon, ask your health plan to give you a notice called the *Notice of Discharge & Medicare Appeal Rights.* This notice will tell you:

- Why you are being discharged.
- The date that we will stop covering your hospital stay (stop paying our share of your hospital costs).
- What you can do if you think you are being discharged too soon.
- Who to contact for help.

You have the right by law to ask for a review of your discharge date. As explained in the *Notice of Discharge & Medicare Appeal Rights*, if you act quickly, you can ask an outside agency called the Quality Improvement Organization to review whether your discharge is medically appropriate.

What is the "Quality Improvement Organization"?

"QIO" stands for **Q**uality **I**mprovement **O**rganization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of the Plan or your hospital.

There is one QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital stay is ending too soon. Section 1 tells how to contact the QIO.

Getting a QIO review of your hospital discharge

If you want to have your discharge reviewed, you must quickly contact the QIO. The *Notice of Discharge & Medicare Appeal Rights* gives the name and telephone number of your QIO and tells you what you must do.

- You must ask the QIO for a **"fast review"** of whether you are ready to leave the hospital. This "fast review" is also called an "immediate review."
- You must be sure that you have made your request to the QIO **no later than** the day you are scheduled to be discharged from the hospital. This deadline is very important. If you meet this deadline, you are allowed to stay in the hospital past your discharge date without paying for it yourself while you wait to get the decision from the QIO (see below).
- The QIO will look at your medical information provided to the QIO by us and the hospital.
- During this process, you will get a notice giving our reasons why we believe that your discharge date is medically appropriate.
- The QIO will decide, within one day after receiving the medical information it needs, whether it is medically appropriate for you to be discharged on the date that has been set for you.

What happens if the QIO decides in your favor?

If the QIO agrees with you, we will continue to cover your hospital stay for as long as it is medically necessary (except for any applicable co-payments or deductibles).

What happens if the QIO denies your request?

If the QIO decides that your discharge date was medically appropriate, you will not be responsible for paying the hospital charges until noon of the day after the QIO gives you its decision. However, you could be financially liable for any inpatient hospital services provided after noon of the day after the QIO gives you its decision. You may leave the hospital on or before that time and avoid any possible financial liability.

If you remain in the hospital, you may still ask the QIO to review its first decision if you make the request within 60 days of receiving the QIO's first denial of your request. However, you could be financially liable for any inpatient hospital services provided after noon of the day after the QIO gave you its first decision.

What happens if you appeal the QIO decision?

The QIO has 14 days to decide whether to uphold its original decision or agree that you should continue to receive inpatient care. If the QIO agrees that your care should continue, we must pay for or reimburse you for any care you have received since the discharge date on the Important Message from Medicare, and provide you with inpatient care as long as it is medically necessary (except for any applicable co-payments or deductibles).

If the QIO upholds its original decision, you may be able to appeal its decision to the Administrative Law Judge. Please see Appeal Level 3 in Part 1 of this section for guidance on the Administrative Law Judge (ALJ) appeal. If the ALJ upholds the decision, you may also be able to ask for a review by the Medicare Appeals Council (MAC) or a Federal court. If any of these decision makers (Administrative Law Judge, Medicare Appeal Council, Federal Court) agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date, and provide you with inpatient care as long as it is medically necessary (except for any applicable co-payments or deductibles)

What if you do not ask the QIO for a review by the deadline?

If you do not ask the QIO for a fast review of your discharge by the deadline, you may ask us for a "fast appeal" of your discharge. How to ask us for a fast appeal is covered in Part 1 of this section.

If you ask us for a fast appeal of your discharge and you stay in the hospital past your discharge date, you may have to pay for the hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to stay in the hospital, we will continue to cover your hospital care for as long as it is medically necessary (except for any applicable co-payments or deductibles).
- If we decide that you should not have stayed in the hospital beyond your discharge date, we will not cover any hospital care you received after the discharge date (unless the independent review organization overturns our decision).

If we uphold our original decision, we will forward our decision and case file to the independent review organization within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the Independent Review Organization (IRO) appeal. If the IRO upholds our decision, you may also be able to ask for a review by an ALJ, MAC, or a Federal court. If any of these decision makers (Independent Review Organization, Administrative Law Judge, Medicare Appeal Council, Federal Court) agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date on the notice you got from your provider, and provide you with any services you asked for as long as they are medically necessary (except for any applicable co-payments or deductibles).

PART 3. Complaints (appeals) if you think your coverage for skilled nursing facility, home health agency or comprehensive outpatient rehabilitation facility services is ending too soon

When you are a patient in a **S**killed **N**ursing **F**acility (SNF), **H**ome **H**ealth **A**gency (HHA), or **C**omprehensive **O**utpatient **R**ehabilitation **F**acility (CORF), you have the right to get all the SNF, HHA or CORF care covered by the Plan that is necessary to diagnose and treat your illness or injury. The day we end your SNF, HHA, or CORF services is based on when these services are no longer medically necessary. This part explains what to do if you believe that your coverage for your services is ending too soon.

Information you will receive during your SNF, HHA or CORF stay

If we decide to end our coverage for your SNF, HHA, or CORF services, you will get written notice either from us or your provider at least 2 calendar days before your coverage ends. You (or your representative) will be asked to sign and date this document to show that you received the notice. Signing the notice does not mean that you agree that coverage should end – it only means that you received and understood the notice.

How to get a review of your coverage by the Quality Improvement Organization

You have the right by law to ask for an appeal of our decision to end coverage for your services. As will be explained in the notice you get from us or your provider, you can ask the **Q**uality **I**mprovement **O**rganization (the "QIO") to do an independent review of whether it is medically appropriate to end coverage for your services.

How soon do you have to ask the QIO to review your coverage?

You must quickly contact the QIO. The written notice you got from us or your provider gives the name and telephone number of your QIO and tells you what you must do.

- If you get the notice 2 days before your coverage ends, you must make your request **no later than noon** of the day after you get the notice.
- If you get the notice and you have more than 2 days before your coverage ends, you must make your request **no later than noon** of the day before the date that your Medicare coverage ends.

What will happen during the QIO review?

The QIO will ask for your opinion about why you believe the services should continue. You do not have to prepare anything in writing, but you may do so if you wish. The QIO will also look at your medical information, talk to your doctor, and review other information that we have given to the QIO. You and the QIO will each get a copy of our explanation about why we believe that your services should end.

The QIO will make this decision within one full day after it receives the information it needs to make a decision.

What happens if the QIO decides in your favor?

We will continue to cover your SNF, HHA, or CORF services for as long as medically necessary (except for any applicable co-payments or deductibles).

What happens if the QIO agrees that your coverage should end?

You will not be responsible for paying for any SNF, HHA, or CORF services provided before the termination date on the notice you get from your provider. You may stop getting services on or before the date given on the notice and avoid any possible financial liability. If you continue receiving services, you may still ask the QIO to review its first decision if you make the request within 60 days of receiving the QIOs first denial of your request.

What happens if you appeal the QIO decision?

The QIO has 14 days to decide whether to uphold its original decision or agree that you should continue to receive services. If the QIO agrees that your services should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider, and provide you with any services you asked for as long as they are medically necessary (except for any applicable co-payments or deductibles).

If the QIO upholds its original decision, you may be able to appeal its decision to the Administrative Law Judge (ALJ). Please see Appeal Level 3 in Part 1 of this section for guidance on the ALJ appeal. If the ALJ upholds our decision, you may also be able to ask for a review by the Medicare Appeals Council or a Federal Court. If either the Medicare Appeal Council or Federal Court agrees that your stay should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider, and provide you with any services you asked for as long as they are medically necessary (except for any applicable co-payments or deductibles).

What if you do not ask the QIO for a review by the deadline?

If you do not ask the QIO for a review by the deadline, you may ask us for a fast appeal. How to ask us for a fast appeal is covered in Part 1 of this section.

If you ask us for a fast appeal of your coverage ending and you continue getting services from the SNF, HHA, or CORF, you may have to pay for the care you receive past your termination date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to continue to get your services covered, we will continue to cover your care for as long as medically necessary.
- If we decide that you should not have continued getting your services covered, we will not cover any care you received after the termination date.

If we uphold our original decision, we will forward our decision and case file to the independent review entity within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the Independent Review Entity (IRE) appeal. If the IRE upholds our decision, you may also be able to ask for a review by an ALJ, MAC, or a Federal court. If any of these decision makers (Independent Review Entity, Administrative Law Judge, Medicare Appeal Council, Federal Court) agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date on the notice you got from your provider, and provide you with any services you asked for as long as they are medically necessary (except for any applicable co-payments or deductibles).

Section 12 What to do if you have complaints about your Part D prescription drug benefits

What to do if you have complaints

We encourage you to let us know right away if you have questions, concerns, or problems related to your prescription drug coverage. Please call Customer Service at the number on the cover of this booklet.

(Please note that Section 12 addresses complaints about your Part D prescription drug benefits. If you have complaints about your MA benefits, you must follow the rules outlined in Section 11.)

This section gives the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your care as a plan member. The Medicare program has helped set the rules about what you need to do to make a complaint and what we are required to do when we receive a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from Advantra Freedom or penalized in any way if you make a complaint.

A complaint will be handled as a grievance, coverage determination, or an appeal, depending on the subject of the complaint.

What is a Grievance?

A grievance is any complaint other than one that involves a coverage determination. You would file a grievance if you have any type of problem with us or one of our network pharmacies that does not relate to coverage for a prescription drug. For example, you would file a grievance if you have a problem with things such as waiting times when you fill a prescription, the way your network pharmacist or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of a network pharmacy. For more information about grievances, including how to file a grievance, see Section 10.

What is a coverage determination?

Whenever you ask for a Part D prescription drug benefit, the first step is called "requesting a coverage determination." If your doctor or pharmacist tells you that a certain prescription drug is not covered, **you must contact us if you want to request a coverage determination.** When we make a coverage determination, we are making a decision whether or not to provide or pay for a Part D drug and what your share of the cost is for the drug. You have the right to ask us for an "exception," which is a type of coverage determination, if you believe you need a drug that is not on our list of covered drugs (formulary) or believe you should get a drug at a lower co-payment. **If you request an exception, your physician must provide a statement to support your request.**

For more information about coverage determinations and exceptions, see the section, "How to request a coverage determination" below.

What is an appeal?

An appeal is any of the procedures that deal with the review of an unfavorable coverage determination. **You cannot request an appeal if we have not issued a coverage determination.** If we issue an unfavorable coverage determination, you may file an appeal called a "redetermination" if you want us to reconsider and change our decision. If our redetermination decision is unfavorable, you have additional appeal rights. For more information about appeals, see the section, "How to request an appeal" below.

How to request a coverage determination

What is the purpose of this section?

This part of Section 12 explains what you can do if you have problems getting the prescription drugs you believe we should provide and you want to request a coverage determination. We use the word "provide" in a general way to include such things as authorizing prescription drugs, paying for prescription drugs, or continuing to provide a Part D prescription drug that you have been getting.

What is a coverage determination?

The coverage determination made by us is the starting point for dealing with requests you may have about covering or paying for a Part D prescription drug. If your doctor or pharmacist tells you that a certain prescription drug is not covered, you should contact us and ask us for a coverage determination. With this decision, we explain whether we will provide the prescription drug you are requesting or pay for a prescription drug you have already received. If we deny your request (this is sometimes called an "adverse coverage determination"), you can "appeal" the decision by going on to Appeal Level 1 (see below). If we fail to make a timely coverage determination on your request, it will be automatically forwarded to the independent review entity for review (see Appeal Level 2 below).

The following are examples of coverage determinations:

- You ask us to pay for a prescription drug you have already received. This is a request for a coverage determination about payment. You can call us at 1-800-690-5924. TDD for the hearing impaired 1-866-236-1069 to get help in making this request.
- You ask for a Part D drug that is not on your plan sponsor's list of covered drugs (called a "formulary"). This is a request for a "formulary exception." You can call us at 1-800-690-5924, TDD for the hearing impaired 1-866-236-1069 to ask for this type of decision. **See "What is an exception" below for more information about the exceptions process.**
- You ask for an exception to our utilization management tools - such as prior authorization, dosage limits, quantity limits, or step therapy requirements. Requesting an exception to a utilization management tool is a type of formulary

exception. You can call us at 1-800-690-5924, TDD for the hearing impaired 1-866-236-1069 to ask for this type of decision. **See "What is an exception" below for more information about the exceptions process.**

- You ask for a non-preferred Part D drug at the preferred cost-sharing level. This is a request for a "tiering exception." You can call us at 1-800-690-5924, TDD for the hearing impaired 1-866-236-1069 to ask for this type of decision. **See "What is an exception" below for more information about the exceptions process.**
- You ask us to reimburse you for a drug you bought at an out-of-network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a physician's office, will be covered by the Plan. See Filling prescriptions outside the network for a description of these circumstances. You can call us at 1-800-690-5924, TDD for the hearing impaired 1-866-236-1069 to make a request for payment or coverage for drugs provided by an out-of-network pharmacy or in a physician's office.

When we make a coverage determination, we are giving our interpretation of how the Part D prescription drug benefits that are covered for members of the Plan apply to your specific situation. This booklet and any amendments you may receive describe the Part D prescription drug benefits covered by us, including any limitations that may apply to these benefits. This booklet also lists exclusions (benefits that are "not covered" by the Plan).

What is an exception?

An exception is a type of coverage determination. You may ask us to make an exception to our coverage rules in a number of situations.

- You may ask us to cover your drug even if it is not on our formulary. Excluded drugs cannot be covered by a Part D plan unless coverage is through an enhanced plan.
- You may ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you may ask us to waive the limit and cover more.
- You may ask us to provide a higher level of coverage for your drug. If your drug is usually considered a Tier 3 drug, you may ask us to cover it as a Tier 2 drug instead. This would lower the co-payment amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug. No other tier exceptions are permitted.

Generally, we will only approve your request for an exception if the alternative drugs included on the Plan's formulary or the low-tiered drug would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

Your doctor must submit a statement supporting your exception request. In order to help us make a decision more quickly, you should include supporting medical information from your doctor when you submit your exception request.

If we approve your exception request, our approval is valid for the remainder of the plan year, so long as your doctor continues to prescribe the drug for you and it continues to be safe and effective for treating your condition. If we deny your exception request, you can appeal our decision.

Note: If we approve your exception request for a non-formulary drug, you cannot request an exception to the co-payment or co-insurance amount we require you to pay for the drug.

Who may ask for a coverage determination?

You, your prescribing physician, or someone you name may ask us for a coverage determination The person you name would be your *appointed representative*. You may name a relative, friend, advocate, doctor, or anyone else to act for you. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and that person must sign and date a statement that gives the person legal permission to act as your appointed representative. This statement must be sent to us at Advantra Freedom, Coventry Health Care, Inc., 3721 TecPort Drive, PO Box 67103, Harrisburg, PA 17106-7103. You can call us at the number on the cover of this booklet to learn how to name your appointed representative.

You also have the right to have an attorney ask for a coverage determination on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify.

Asking for a “standard" or "fast" coverage determination

Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard time frame?

A decision about whether we will cover a Part D prescription drug can be a “standard" coverage determination that is made within the standard time frame (typically within 72 hours; see below), or it can be a “fast" coverage determination that is made more quickly (typically within 24 hours; see below). A fast decision is sometimes called an “expedited coverage determination.”

You may ask for a fast decision **only** if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for Part D drugs that you have not received yet. You cannot get a fast decision if you are requesting payment for a Part D drug that you already received.)

Asking for a standard decision

To ask for a standard decision, you, your doctor, or your appointed representative should:

- Call us at 1-888-816-7671 (for TTY, call 1-866-236-1069).
- Or, you can deliver a written request to:

  Advantra Freedom
  MAPD Clinical Call Center
  3721 TecPort Drive
  P.O. Box 67103
  Harrisburg, PA 17106-7103
- Or fax it to 1-877-554-9139.
- After hours your doctor may fax requests to 1-877-554-9139 which will be handled the next business day or call Caremark, Advantra's pharmacy benefits administrator, at 1-800-421-2342.

Asking for a fast decision

You, any doctor, or your representative can ask us to give a "fast" decision (rather than a "standard" decision) about medical care by:

- Calling us at 1-877-337-4178

  Monday-Friday 8 a.m. – 11 p.m. Eastern Time

  (for TTY, call 1-866-386-2335).
- Or, you may deliver a written request to:

  Advantra Freedom

  MAPD Clinical Call Center
  3721 TecPort Drive
  P.O. Box 67103 Harrisburg, PA 17106-7103,
- Or fax it to 1-877-554-9139.
- After hours your doctor may fax requests to 1-877-554-9139 which will be handled the next business day or call Medco, Advantra's pharmacy benefits administrator, at 1-800-922-1557.

The Caremark agent will notify your doctor that if this is an emergency, the pharmacy provider may enter an override code which will cover a 72 hour supply. Your prescribing doctor may then call the clinical call center once it re-opens to request a long term exception. If your doctor requires an immediate response, Caremark will contact the Advantra on-call pharmacist who will respond to the prescriber as quickly as possible.

Your prescribing doctor needs to provide the following information:

- Your full name (First name and Last name)
- Your Coventry Advantra Member ID number
- Requested drug
- Reason for the request

Be sure to ask for a "fast," "expedited," or "24-hour" review.

- If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.
- If you ask for a fast coverage determination without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast coverage determination, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review. If we deny your request for a fast coverage determination, we will give you our decision within the 72 hour standard time frame.

What happens when you request a coverage determination?

What happens, including how soon we must decide, depends on the type of decision.

1. **For a <u>standard</u> coverage determination about a Part D drug, which includes a request about payment for a Part D drug that you already received.**

   Generally, we must give you our decision no later than 72 hours after we have received your request, but we will make it sooner if your health condition requires. However, if your request involves a request for an exception (including a formulary exception, tiering exception, or an exception from utilization management rules - such as dosage or quantity limits or step therapy requirements), we must give you our decision no later than 72 hours after we have received your doctor's "supporting statement," which explains why the drug you are asking for is medically necessary.

   If you are requesting an exception, you should submit your prescribing doctor's supporting statement with the request, if possible.

   We will give you a decision in writing about the prescription drug you have requested. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. The section, "Appeal Level 1" explains how to file this appeal.

   If you have not received an answer from us within 72 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent review organization will review your case.

2. **For a <u>fast</u> coverage determination about a Part D drug that you have not received.**

   If you receive a fast review, we will give you our decision within 24 hours after you or your doctor ask for a fast review - sooner if your health requires. If your request involves a request for an exception, we will give you our decision no later than 24 hours after we have received your doctor's "supporting statement," which explains why the non-formulary or non-preferred drug you are asking for is medically necessary.

   We will give you a decision in writing about the prescription drug you have requested. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. The section, "Appeal Level 1" explains how to file this appeal.

   If we decide you are eligible for a fast review, and you have not received an answer from us within 24 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent review organization will review your case.

   If we do not grant your or your doctor's request for a fast review, we will give you our decision within the standard 72 hour time frame discussed above.

What happens if we decide completely in your favor?

If we make a coverage determination that is completely in your favor, what happens next depends on the situation.

1. **For a <u>standard</u> decision about a Part D drug, which includes a request about payment for a Part D drug that you already received.**

   We must authorize or provide the Part D drug you requested as quickly as your health requires, but no later than 72 hours after we received the request. If your request involves a request for an exception, we must authorize or provide the Part D drug you requested no later than 72 hours after we have received your doctor's "supporting statement." If you are requesting reimbursement for a Part D drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request.

2. **For a <u>fast</u> decision about a Part D drug that you have not received.**

   We must authorize or provide you with the Part D drug you requested no later than 24 hours of receiving your request. If your request involves a request for an exception, we must authorize or provide the Part D drug no later than 24 hours after we have received your doctor's "supporting statement."

What happens if we deny your request?

If we deny your request, we will send you a written decision explaining the reason why your request was denied. We may decide *completely* or only *partly* against you. For example, if we deny your request for payment for a Part D drug that you have already received, we may say that we will pay nothing or only part of the amount you requested.

If a coverage determination does not give you *all* that you requested, you have the right to appeal the decision. (See Appeal Level 1.)

How to request an appeal

This part of Section 12 explains what you can do if you disagree with our coverage determination decision.

What kinds of decisions can be appealed?

If you are not satisfied with our coverage determination decision, you may ask for an appeal called a "redetermination." You may generally appeal the following decisions:

- We do not cover a Part D drug you think you are entitled to receive,
- We do not pay you back for a Part D drug that you paid for,
- We paid you less for a Part D drug than you think we should have paid you,
- We ask you to pay a higher co-payment amount than you think you are required to pay for a Part D drug, or
- We deny your exception request.

How does the appeals process work?

There are five levels to the appeals process. Here are a few things to keep in mind as you read the description of these steps in the appeals process:

- **Moving from one level to the next.** At each level, your request for Part D prescription drug benefits or payment is considered and a decision is made. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may be completely denied (turned down). If you are not satisfied with the decision, there may be another step you can take to get further review of your request. Whether you are able to take the next step may depend on the dollar value of the requested drug or on other factors.
- **Who makes the decision at each level?** You make your request for coverage or payment of a Part D prescription drug directly to us. We review this request and make a coverage determination. If our coverage determination is to deny any part of your request, you can go on to the first level of appeal by asking us to review our coverage determination. If you are still not satisfied with the outcome, you may ask for further review. If you ask for further review, your appeal is sent outside of Advantra Freedom, where people who are not connected to us review your case and make the decision. After the first level of appeal, all subsequent levels of appeal will be decided by someone who is connected to the Medicare program or the federal court system. This will help ensure a fair, impartial decision.

Each appeal level is discussed in greater detail below.

Appeal Level 1: If we deny any part of your request in our coverage determination, you may ask us to reconsider our decision. This is called an "appeal" or "request for redetermination."

Please call us at the number on the cover of this booklet if you need help with filing your appeal. You may ask us to reconsider our coverage determination, even if only part of our decision is not what you requested. When we receive your request to reconsider the coverage determination, we give the request to people at our organization who were not involved in making the coverage determination. This helps ensure that we will give your request a fresh look.

How you make your appeal depends on whether you are requesting reimbursement for a Part D drug you already received and paid for, or authorization of a Part D benefit (that is, a Part D drug that you have not yet received). If your appeal concerns a decision we made about authorizing a Part D benefit that you have not received yet, then you and/or your doctor will first need to decide whether you need a fast appeal. The procedures for deciding on a standard or a fast *appeal* are the same as those described for a standard or fast *coverage determination*. Please see the discussion under *"*Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard time frame?" and "Asking for a fast decision." Fast Decisions are sent to our pharmacy area, but Fast appeals are sent to our appeals and grievance area at noted below.

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to your request, or you may want to get your doctor's records or opinion to help support your request. You may need to give the doctor a written request to get information.

You may give us your additional information in any of the following ways:

- In writing, to Advantra Freedom, Attn: Appeals Department, 500 Virginia Street East, Suite 400, Charleston, WV 25301.
- By fax, at 1-800-535-4047.
- By telephone —if it is a fast appeal—at 1-866-275-9280 Monday – Friday 8 a.m. – 5 p.m. Eastern Time, hearing impaired members should call our TDD number at 1-866-386-2335.
- You also have the right to ask us for a copy of information regarding your appeal. You can call us at the number on the front of this booklet or write, Advantra Freedom, Attn: Appeals Department, 500 Virginia Street East, Suite 400, Charleston, WV 25301.

Who may file your appeal of the coverage determination?

You or your appointed representative may file a **standard appeal** request.

You, your appointed representative, or your doctor may file a **fast appeal** request.

How soon must you file your appeal?

You must file your appeal within 60 calendar days from the date included on the notice of our coverage determination. We may give you more time if you have a good reason for missing the deadline.

How to file your appeal

1. Asking for a standard appeal

To ask for a standard appeal, you or your appointed representative may send a written appeal request to us at Advantra Freedom, Attn: Appeals Department, 500 Virginia Street East, Suite 400, Charleston, WV 25301.

2. Asking for a fast appeal

The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination. You, your doctor, or your appointed representative can ask us to give a fast appeal (rather than a standard appeal) by calling us at 1-866-275-9280 Monday – Friday 8 a.m. – 5 p.m. Eastern Time, hearing impaired members should call our TDD number at 1-866-386-2335. Or, you can deliver a written request to Advantra Freedom, Attn: Appeals Department, 500 Virginia Street East, Suite 400, Charleston, WV 25301 or fax it to 1-800-535-4047. Be sure to ask for a "fast," "expedited," or "72-hour" review. Remember, that if your prescribing doctor provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically treat you as eligible for a fast appeal. Fast Decisions are sent to our pharmacy area, but Fast appeals are sent to our appeals and grievance area.

How soon must we decide on your appeal?

How quickly we decide on your appeal depends on the type of appeal:

1. **For a standard decision about a Part D drug, which includes a request for reimbursement for a Part D drug you already paid for and received.**

   We will give you our decision within seven (7) calendar days after we receive your appeal request. ,We will give you the decision sooner if your health condition requires us to. If we do not give you our decision within seven (7) calendar days, your request will *automatically* go to the second level of appeal, where an independent review organization will review your case.

2. **For a fast decision about a Part D drug that you have not received.**

   We will give you our decision within 72 hours after we receive your appeal request. We will give you the decision sooner if your health requires us to. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2, where an independent review organization will review your case.

What happens next if we decide completely in your favor?

1. **For a standard decision about reimbursement for a Part D drug you already paid for and received.**

   We must send payment to you no later than thirty (30) calendar days after we receive your request to reconsider our coverage determination.

2. **For a standard decision about a Part D drug you have not received.**

   We must authorize or provide you with the Part D drug you have asked for as quickly as your health requires, but no later than seven (7) calendar days after we received your appeal request.

3. **For a fast decision about a Part D drug you have not received.**

   We must authorize or provide you with the Part D drug you have asked for as quickly as your health requires, but no later than 72 hours after we received your appeal request.

Appeal Level 2: If we deny any part of your first appeal, you may ask for a review by a government-contracted independent review organization.

What independent review organization does this review?

At the second level of appeal, your appeal is reviewed by an outside, independent review organization that has a contract with the **C**enters for **M**edicare & Medicaid **S**ervices (CMS), the government agency that runs the Medicare program. The independent review organization has no connection to us. You have the right to ask us for a copy of your case file that we sent to this organization.

Who may file your appeal?

You or your appointed representative may file a **standard** or **fast** appeal request.

How soon must you file your appeal?

You must file the appeal request within sixty (60) calendar days after the date you were notified of the decision on your first appeal. The independent review organization may give you more time if you have a good reason for missing the deadline.

How to file your appeal

1. Asking for a standard appeal

To ask for a standard appeal, you or your appointed representative may send a written appeal request to us

2. Asking for a fast appeal

The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination, except your prescribing doctor cannot file the request for you. Only you or your appointed representative may file the written appeal request to the independent review organization at the address included in the redetermination notice your receive from us. Remember, if your prescribing doctor provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically treat you as eligible for a fast appeal.

How soon must the independent review organization decide?

After the independent review organization receives your appeal, how long the organization can take to make a decision depends on the type of appeal:

1. For a standard decision about a Part D drug that includes a request about reimbursement for a Part D drug that you have already paid for and received.

   The independent review organization will give you its decision within seven calendar days after they receive your appeal request. The independent review organization will make the decision sooner if your health condition requires it. If your request involves an exception to the Plan's formulary, the time frame begins once the independent review organization receives your doctor's supporting statement.

2. For a fast decision about a Part D drug that you have not received.

   The independent review organization will give you its decision within 72 hours after they receive your appeal request. The independent review organization will make the decision sooner if your health condition requires it. If your request involves an exception to the Plan's formulary, the time frame begins once the independent review organization receives your doctor's supporting statement.

If the independent review organization decides completely in your favor:

The independent review organization will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. **For a decision about reimbursement for a Part D drug you already paid for and received.**

   We must send payment within thirty (30) calendar days from the date we receive notice reversing our coverage determination.

2. **For a standard decision about a Part D drug you have not received.**

   We must authorize or provide you with the Part D drug you have asked for within 72 hours after we receive notice reversing our coverage determination.

3. **For a fast decision about a Part D drug you have not received.**

   We must authorize or provide you with the Part D drug you have asked for within 24 hours after we receive notice reversing our coverage determination.

Appeal Level 3: If the organization that reviews your case in Appeal Level 2 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

If the independent review organization does not rule completely in your favor, you or your appointed representative may ask for a review by an Administrative Law Judge, if the dollar value of the contested Part D drug meets the minimum requirement provided in the independent review organization's decision. During the Administrative Law Judge review, you may present evidence, review the record (by either receiving a copy of the file or accessing the file in person when feasible), and be represented by counsel.

Who may file your appeal?

You or your appointed representative may file an appeal request with an Administrative Law Judge.

How soon must you file your appeal?

The appeal request must be filed within sixty (60) calendar days after the date you were notified of the decision made by the independent review organization (Appeal Level 2). The Administrative Law Judge may give you more time if you have a good reason for missing the deadline.

How to file your appeal

The request must be filed with an Administrative Law Judge in writing. The written request must be sent to the Administrative Law Judge at the address listed in the decision you receive from the independent review organization (Appeal Level 2).

The Administrative Law Judge will not review your appeal if the dollar value of the requested Part D drug(s) does not meet the minimum requirement provided in the independent review organization's decision. If the dollar value is less than the minimum requirement, you may not appeal any further.

How is the dollar value (the "amount remaining in controversy") calculated?

If we have refused to provide Part D prescription drug benefits, the dollar value for requesting an Administrative Law Judge hearing is based on the projected value of those benefits. The projected value includes:

- Any costs you could incur based on what you would be charged for the drug and the number of refills prescribed for the requested drug during the Plan year.
- Your co-payments,

- All drug expenses after your drug costs exceed the initial coverage limit, and
- Payments for drugs made by other entities on your behalf.

You may also combine multiple Part D claims to meet the dollar value if:

1. The claims involve the delivery of Part D prescription drugs to you;
2. All of the claims have received a determination by the independent review organization as described in Appeal Level 2;
3. Each of the combined requests for review are filed in writing within sixty (60) calendar days after the date that each decision was made at Appeal Level 2; and
4. Your hearing request identifies all of the claims to be heard by the Administrative Law Judge.

How soon does the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

If the Judge decides in your favor

The Administrative Law Judge will tell you in writing about his or her decision and the reasons for it. What happens next depends on the type of appeal:

1. **For a decision about <u>payment</u> for a Part D drug you already received.**

   We must send payment to you no later than thirty (30) calendar days after we receive notice reversing our coverage determination.

2. **For a standard decision about a Part D drug you have not received.**

   We must authorize or provide you with the Part D drug you have asked for within 72 hours after we receive notice reversing our coverage determination.

3. **For a fast decision about a Part D drug you have not received.**

   We must authorize or provide you with the Part D drug you have asked for within 24 hours after we receive notice reversing our coverage determination.

Appeal Level 4: If an ALJ does not rule in your favor, your case may be reviewed by the Medicare Appeals Council

If the Administrative Law Judge does not rule completely in your favor, you or your appointed representative may ask for a review by the Medicare Appeals Council.

Who may file your appeal?

<u>You</u> or <u>your appointed representative</u> may request an appeal with the Medicare Appeals Council.

How to file your appeal

The request must be filed with the Medicare Appeals Council. The decision you receive from the Administrative Law Judge (Appeal Level 3) will tell you how to file this appeal.

How soon must you file your appeal?

The appeal request must be filed within 60 calendar days after the date you were notified of the decision made by the Administrative Law Judge (Appeal Level 3). The Medicare Appeals Council may give you more time if you have a good reason for missing the deadline.

How soon will the Council make a decision?

The Medicare Appeals Council will first decide whether to review your case (it does not review every case it receives). If Medicare Appeals Council reviews your case, it will make a decision as soon as possible. If it decides not to review your case, then you may request a review by a Federal Court Judge (see Appeal Level 5). The Medicare Appeals Council will issue a written notice explaining any decision it makes. The notice will tell you how to request a review by a Federal Court Judge.

If the Council decides in your favor

The Medicare Appeals Council will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. **For a decision about payment for a Part D drug you already received.**

   We must send payment to you no later than thirty (30) calendar days after we receive notice reversing our coverage determination.

2. **For a standard decision about a Part D drug you have not received.**

   We must authorize or provide you with the Part D drug you have asked for within 72 hours after we receive notice reversing our coverage determination.

3. **For a fast decision about a Part D drug you have not received.**

   We must authorize or provide you with the Part D drug you have asked for within 24 hours after we receive notice reversing our coverage determination.

If the Council decides against you

If the amount involved meets the minimum requirement provided in the Medicare Appeals Council's decision, you have the right to continue your appeal by asking a Federal Court Judge to review the case (Appeal Level 5). The letter you get from the Medicare Appeals Council will tell you how to request this review. If the value is less than the minimum requirement the Council’s decision is final and you may not take the appeal any further.

Appeal Level 5: If the Medicare Appeals Council does not rule in your favor, your case may go to a Federal Court.

You have the right to continue your appeal by asking a Federal Court Judge to review your case if:

- The amount involved meets the minimum requirement specified in the Medicare Appeals Council's decision,
- You received a decision from the Medicare Appeals Council (Appeal Level 4), and:
- The decision is not completely favorable to you, or
- The decision tells you that the Medicare Appeals Council decided not to review your appeal request.

Who may file your appeal?

You or your appointed representative may request an appeal with a Federal Court.

How soon must you file your appeal?

The appeal request must be filed within 60 calendar days after the date you were notified of the decision made by the Medicare Appeals Council (Appeal Level 4).

How to file your appeal

In order to request judicial review of your case, you must file a civil action in a United States district court. The letter you get from the Medicare Appeals Council in Appeal Level 4 will tell you how to request this review.

Your appeal request will not be reviewed by a Federal Court if the dollar value of the requested Part D drug(s) does not meet the minimum requirement specified in the Medicare Appeals Council's decision.

How soon will the Judge make a decision?

The Federal Court Judge will first decide whether to review your case. If it reviews your case, a decision will be made according to the rules established by the Federal judiciary.

If the Judge decides in your favor:

1. **For a decision about payment for a Part D drug you already received.**

   We must send payment to you within thirty (30) calendar days after we receive notice reversing our coverage determination.

2. **For a standard decision about a Part D drug you have not received.**

We must authorize or provide you with the Part D drug you have asked for within 72 hours after we receive notice reversing our coverage determination.

3. **For a fast decision about a Part D drug you have not received.**

   We must authorize or provide you with the Part D drug you have asked for within 24 hours after we receive notice reversing our coverage determination.

If the Judge decides against you:

The Judge's decision is final and you may not take the appeal any further.

Section 13 Leaving Advantra Freedom and your choices for continuing Medicare after you leave

Some employer groups have special rules about when you can and cannot disenroll. Contact PEIA for specific disenrollment information. Disenrolling from Advantra Freedom may result in the loss of other employer group benefits.

Ending your membership in our Plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave Advantra Freedom because you have decided that you *want* to leave.
- There are also limited situations where are *required* to end you membership. For example, if you do *not* stay continuously enrolled in both Medicare Part A and Medicare Part B.

Voluntarily ending your membership

In general, there are only certain times during the year when you may voluntarily end your membership in our Plan.

Every year, from November 15 through December 31, during the Annual Coordinated Election Period (AEP), anyone with Medicare may switch from one way of getting Medicare to another for the following year. Your change will take effect on January 1.

There may be other limited times during which you may make changes. For more information about these times and the options available to you, please refer to the "Medicare & You" handbook you receive each fall. You may also call 1-800-MEDICARE (1-800-633-4227), or visit **www.medicare.gov** to learn more about your options.

Until your membership ends, you must keep getting your Medicare services through our Plan or you will have to pay more for the services yourself

Until your prescription drug coverage with our Plan ends, use our network pharmacies to fill your prescriptions. While you are waiting for your membership to end, you are still a member and must continue to get your prescription drugs as usual through our Plan's network pharmacies. In most cases, your prescriptions are covered only if they are filled at a network pharmacy or through our mail-order-pharmacy service, are listed on our formulary, and you follow other coverage rules.

We *cannot* ask you to leave the plan because of your health

No member of any Medicare health plan can be asked to leave the plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave our Plan because of your health, you should call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Involuntarily ending your membership

If any of the following situations occur, we will end your membership in Advantra Freedom.

- **If you move out of the service area or are away from the service area for more than six months in a row.** If you plan to move or take a long trip, please call Customer Service at the number on the cover of this booklet to find out if the place you are moving to or traveling to is in our Plan's service area. If you move permanently out of our geographic service area, or if you are away from our service area for more than six months in a row, you generally cannot remain a member of our Plan. In these situations, if you do not leave on your own, we must end your membership ("disenroll" you).
- If you do *not* stay continuously enrolled in both Medicare Part A and Medicare Part B
- If you give us information that you know is false or deliberately misleading, and it affects whether or not you can enroll in our Plan.
- If you behave in a way that is disruptive, to the extent that your continued enrollment seriously impairs our ability to arrange or provide medical care for you or for others who are members of our Plan. We cannot make you leave our Plan for this reason unless we get permission first from Medicare.
- If you let someone else use your plan membership card to get medical care. If you are disenrolled for this reason, CMS may refer your case to the Inspector General for additional investigation.
- If you do not pay the Plan premiums (if applicable), we will tell you in writing that you have a 30-day grace period during which you can pay the Plan premiums before your membership ends.

You have the right to make a complaint if we end your membership in our Plan

If we ask you to end your membership in our Plan, we will tell you our reasons in writing and explain how you can file a complaint against us if you want to.

Section 14 Legal notices

Notice about governing law

Many different laws apply to this Evidence of Coverage. Some additional provisions may apply to your situation because they are required by law. This can affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the **C**enters for **M**edicare & Medicaid **S**ervices, or CMS. In addition, other federal laws may apply and, under certain circumstances, the laws of the State(s) may apply.

Notice about non-discrimination

When we make decisions about the provision of health care services, we do not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans or Medicare Prescription Drug Plans, like our Plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that receive federal funding, and any other laws and rules that apply for any other reason.

Section 15 Definitions of some words used in this book

Appeal – An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for health care services or Part D drug benefits or payment for services or Part D drug benefits you already received. You may also make a complaint if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if Medicare doesn't pay for an item or service you think you should be able to get.

Balance Billing – Physicians, occupational therapists or durable medical equipment suppliers that do not Accept Medicare Assignment and choose to bill the Medicare beneficiary for the balance of their private fees that exceed the Medicare Allowed Charges, not to exceed the Medicare Excess/Limiting Charge or the maximum charge amount permitted under State law.

Benefit period – For both our Plan and the Original Medicare Plan, a benefit period is used to determine coverage for inpatient stays skilled nursing facilities. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. The type of care you actually get during the stay determines whether you are considered an inpatient for SNF stays, but not for hospital stays.

You are an inpatient in a SNF only if your care in the SNF meets certain standards for skilled level of care. Specifically, in order to be an inpatient in a SNF, you must need daily skilled-nursing or skilled-rehabilitation care, or both.

Brand-Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage - The phase in the Part D Drug Benefit where you pay a low co-payment or coinsurance for your drugs after you or other qualified parties on your behalf have spent [$4,350] in covered drugs during the covered year. This does not apply to the PEIA benefit.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs the Medicare program.

Co-insurance – A percentage of the cost of a Covered Service an Enrollee is required to pay either at the time of service or when billed by the Provider. An Enrollee's co-insurance amount is based on Medicare Allowable Charges.

Cost-sharing - Cost-sharing refers to amounts that a member has to pay when services are received. It includes any combination of the following three types of payments: (1) any deductible amount the plan may impose before services are covered; (2) any fixed "co-payment" amounts that a plan may require be paid when specific services are received; or (3) any "co-insurance" amount that must be paid as a percentage of the total amount paid for a service.

Coverage Determination - The Plan has made a coverage determination when it makes a decision about the benefits you can receive under the Plan, and the amount that you must pay for those benefits. A decision from your Medicare drug plan about whether a drug prescribed for you is covered by the Plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription is not covered under your plan, that is not a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage if you disagree .

Covered Drugs – The general term we use to mean all of the prescription drugs covered by our Plan.

Covered services – The general term we use in this booklet to mean all of the health care services and supplies that are covered by our Plan.

Creditable Prescription Drug Coverage - Prescription drug coverage (for example, from an employer or union) that is expected to pay as much as standard Medicare prescription drug coverage

Customer Service – A department within our Plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See the cover for information about how to contact Customer Service.

Deemed provider - A provider is a deemed provider and must follow a PFFS plan's terms and conditions of payment if the following conditions are met: a) In advance of

furnishing services the provider knows that a patient is enrolled in a PFFS plan and b) the provider either possesses or has access to the plan's terms and conditions of payment.

It is important to note that a provider is not required to furnish health care services to enrollees of a PFFS plan. However, when a provider chooses to furnish services to a PFFS enrollee and the deeming conditions have been met, the provider is automatically a deemed provider (for that enrollee) and must follow the PFFS plan's terms and conditions of payment.

Disenroll or disenrollment – The process of ending your membership. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice).

Durable medical equipment – Equipment needed for medical reasons, which is sturdy enough to be used many times without wearing out. A person normally needs this kind of equipment only when ill or injured. It can be used in the home. Examples of durable medical equipment are wheelchairs, hospital beds, and equipment that supplies a person with oxygen.

Emergency care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition.

Evidence of Coverage and Disclosure Information – This document, along with your enrollment form and any other attachments, which explains your coverage, what we must do, your rights, and what you have to do as a member of our Plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the Plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Formulary – A list of covered drugs provided by the Plan.

Generic Drug – A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand-name drugs.

Grievance – A type of complaint you make about us or one of our Plan providers, including a complaint concerning the quality of your care. This type of complaint does not involve payment or coverage disputes.

Home health aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Home health care – Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Section 4 under the heading "Home health care." If you need home health care services, our Plan will cover these services for you provided the Medicare coverage requirements are met. Home health care can include services from a **home health aide** if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice care – A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain. The focus is on care, not cure. For more information on hospice care visit www.medicare.gov and under "Search Tools" choose "Find a Medicare Publication" to view or download the publication "Medicare Hospice Benefits." Or, call 1-800-MEDICARE

Initial Coverage Limit – The maximum limit of coverage under the initial coverage period.

Initial Coverage Period – This is the period after you have met your deductible (if you have one) and before your total drug expenses, have reached including amounts you have paid and what our Plan has paid on your behalf.

Inpatient Care – Health care that you get when you are admitted to a hospital.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you do not join a plan when you are first able. You pay this higher amount as long as you have Medicare. There are some exceptions. If you do not have creditable prescription drug coverage, you will have to pay a penalty in addition to your monthly plan premium.

Medically necessary – Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for your convenience or that of your doctor.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with permanent kidney failure (who need dialysis or a kidney transplant).

Medicare Advantage Plan with Prescription Drug Coverage –A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. In most cases, Medicare Advantage Plans also offer Medicare prescription drug coverage. A Medicare Advantage Plan can be an HMO, PPO, or a Private Fee-for-Service Plan. PEIA has selected the Private Fee-for-Service Plan.

Medicare Advantage Organization –Medicare Advantage Plans are run by private companies. They give you more options, and sometimes, extra benefits. These plans are still part of the Medicare Program and are also called “Part C.” They provide all your Part A (Hospital) and Part B (Medical) coverage. Some may also provide Part D (prescription drug) coverage.

“Medigap” (Medicare supplement insurance) policy – Medicare Supplement Insurance sold by private insurance companies to fill “gaps” in the Original Medicare Plan coverage. Medigap policies only work with the Original Medicare Plan.

Member (member of our Plan, or “plan member”) – A person with Medicare who is eligible to get covered services, who has enrolled in our Plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network Pharmacy – A network pharmacy is a pharmacy where members of our Plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Non-plan provider or non-plan facility – Non-plan providers are providers with whom we do not have a written contract. The Plan has an open network; all providers and facilities are considered non-plan. As explained in this booklet, if a non-plan provider who has agreed to provide you plan-covered services, has been informed by you, say, by showing them your member ID card, that you are a member of the Plan, then that provider is deemed to have a contract. In particular, you do not have to pay this provider more than the plan required cost-sharing for the services since the plan will pay the rest of the bill. On the other hand when the above mentioned deeming conditions are not met, for example if the enrollee is unconscious, then the provider furnishing the enrollee services is considered non-contracting.

Organization Determination - The MA organization has made an organization determination when it, or one of its providers, makes a decision about MA services or payment that you believe you should receive.

Original Medicare – Some people call it "traditional Medicare" or "fee-for-service" Medicare. The Original Medicare Plan is the way many people get their health care coverage. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that does not have a contract with our Plan to coordinate or provide covered drugs to members of our Plan. As explained in this Evidence of Coverage, most services you get from non-network pharmacies are not covered by our Plan unless certain conditions apply.

Part D – The voluntary Prescription Drug Benefit Program. (For ease of reference, we will refer to the new prescription drug benefit program as Part D.) PEIA has a Part D benefit with this Plan.

Part D Drugs – Drugs that Congress permitted our Plan to offer as part of a standard Medicare prescription drug benefit. We may or may not offer all Part D drugs, see your formulary for a specific list of covered drugs. Certain categories of drugs, such as benzodiazepines and barbiturates, and over-the-counter drugs were specifically excluded by Congress from the standard prescription drug package. These drugs are not considered Part D drugs. PEIA has an expanded list of CMS Excluded drugs in the formulary that may cover some of these drugs excluded by Congress for standard drug packages.

Plan provider – "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "**plan providers**" when they accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our Plan. Our Plan pays plan providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services..

Prior authorization – Approval in advance to get services or certain drugs that may or may not be on our formulary. Some drugs are covered only if your doctor or other plan provider gets "prior authorization" our Plan. Covered drugs that need prior authorization are marked in the formulary.

Private Fee-for-Service Plan – An MA private fee-for-service plan is an MA plan that pays providers of services at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk. An MA Organization wishing to offer a PFFS plan must meet general requirements for MA Organizations required by law including:

- Providing for all original Medicare covered services;
- Providing for emergency and urgent care;
- Allowing beneficiary appeals for services that are limited, not provided, not paid for, or not allowed and
- Disclosing its terms and conditions of payment and a list of services it provides.

An MA Organization offering a PFFS plan:

- Does not vary the rates for a provider based on the utilization of that provider's services;
- Does not restrict enrollees' choices among providers that (a) agree to accept the plan's terms and conditions of payment and (b) are lawfully authorized to provide services; and
- Does not limit enrollees to a provider network (no"lock-in").

Special access rules apply to PFFS plans.

Members of a PFFS plan may go to any doctor or hospital in the U.S. that is:

- eligible to be paid by Medicare (that is (a) the provider is state licensed, (b)is eligible to receive, or has received, a Medicare billing number, and, (c) for Institutional providers, such as hospitals and skilled nursing facilities, is certified to treat Medicare beneficiaries); and
- is willing to accept the plan's terms and conditions of payment.

PFFS plans may offer supplemental benefits.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts that are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare Providers.

Quantity Limits - A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Rehabilitation services – These services include physical therapy, cardiac rehabilitation, speech and language therapy, and occupational therapy that are provided under the direction of a plan provider.

Skilled Nursing Facility (SNF) care – A level of care in a SNF ordered by a doctor that must be given or supervised by licensed health care professionals. It may be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services are physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment, such as how to use a walker or get in and out of a wheelchair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to perform usual daily activities, such as eating and dressing by yourself.

Step Therapy - A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Terms and conditions of participation (payment) – The PFFS terms and conditions of participation establish the rules that providers must follow if they choose to furnish services to an enrollee of a PFFS plan. At a minimum the terms and conditions will specify:

- A list of all services that the plan provides;
- The amount the PFFS organization will pay for all plan-covered services;
- Provider billing procedures;
- The amount the provider is permitted to collect from the enrollee including balance billing; and
- The PFFS plan is not required to reimburse providers for services to PFFS plan enrollees, if these services are not covered by the plan or by Original Medicare.

A private fee-for-service organization is required to make its terms and conditions of participation reasonably available--through phone, fax, email, or websites-- to providers in the U.S. from whom its enrollees seek health care services.

Exhibit 1 – Part "B" Drug Coverage Formulary

The following types of drugs are covered under Part B of the Original Medicare Plan. Members of our Plan receive coverage for these drugs through our Plan. These may include but are not limited to the following types of drugs;

- Drugs that usually are not self-administered by the patient and are injected while you are getting physician services
- Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the Plan
- Clotting factors given by injection to hemophiliacs
- Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant
- Injectable osteoporosis drugs for certain women who have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot be self-administered
- Antigens
- Certain oral anti-cancer drugs and anti-nausea drugs
- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoisis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)
- Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases

Additionally, members of our Plan can actually fill prescriptions at the pharmacy for specific drugs from the types mentioned above. In an effort to clarify further what specific drugs are covered under your Part B benefit at the pharmacy, we have provided a listing of those drugs by Therapeutic Class, Drug Name, Form, Strength, and any additional limits that may apply. The formulary lists specific dugs in the following Therapeutic Classes:

- Oral anti-cancer drugs
- Anti-nausea drugs when used in conjunction with chemotherapy
- Diabetes testing supplies
- Insulin (when used in an insulin pump)
- Respiratory drugs (administered via a nebulizer)
- Transplant (immunosuppressant) drugs

The information in the "Limits-Notes" column tells you if we have any special requirements for coverage of your drug or we ask that you notify us of your intent to purchase any drugs listed in this formulary.

The following abbreviations may be used in the "Limits-Notes" column;

- **PN – Prior Notification:** We ask you or your physician to notify us of your intent to purchase this drug before you fill your prescriptions. In some situations, certain drugs may be covered under Part D as opposed to Part B. Advantra Freedom PFFS needs to be able to make a decision before services are rendered so that claims are processed appropriately and/or redirected to another carrier if appropriate. Advantra Freedom PFFS also has a preferred Part B drug list. Using drugs on this list could result in savings to you.
- **QL – Quantity Limits:** For certain drugs, we limit the amount of the drug that the Plan will cover.
- **90D – 90 days Maintenance Supply:** We allow these medications for an extended supply up to 90 days.

THERAPEUTIC CLASS	DRUG NAME	FORM	STRENGTH	LIMITS-NOTES
CANCER	ALKERAN	TABS	2MG	PN
CANCER	*cabergoline*	TABS	0.5MG	
CANCER	*cyclophosphadmide*	TABS	25MG, 50MG	PN
CANCER	ETOPOSIDE	CAPS	50MG	PN
CANCER	*methotrexate*	TABS	2.5MG	90D
CANCER	MYLERAN	TABS	2MG	PN
CANCER	TEMODAR	CAPS	5MG, 20MG, 100MG, 140MG, 180MG, 250MG	PN
CANCER	XELODA	TABS	150MG, 500MG	PN
DIABETES	CONTROL SOLUTION	LIQD		90D
DIABETES	LANCETS	MISC		90D
DIABETES	LANCING DEVICE	MISC		90D
DIABETES	LIFESCAN BLOOD GLUCOSE MONITOR	KIT		QL (1 per year)

THERAPEUTIC CLASS	DRUG NAME	FORM	STRENGTH	LIMITS-NOTES
DIABETES	LIFESCAN TEST STRIPS	STRP		QL (100 per 30D); 90D
DIABETES	NOVOLIN R VIAL	SOLN	100UNIT/ML	PN-Insulin Pump use; 90D
DIABETES	NOVOLOG VIAL	SOLN	100UNIT/ML	PN-Insulin Pump use; 90D
NAUSEA	ANZEMET	TABS	50MG, 100MG	PN; QL (5 per 30D)
NAUSEA	CESAMET	CAPS	1MG	PN; QL (30 per 30D)
NAUSEA	*chlorpromazine hcl*	TABS	10MG, 25MG, 50MG 100MG, 200MG	
NAUSEA	*diphenhydramine hcl*	CAPS	50MG	
NAUSEA	*dronabinol*	CAPS	2.5MG, 5MG, 10MG	PN; QL (60 per 30D)
NAUSEA	EMEND	MISC	TRIPAK	QL (3 per 30D)
NAUSEA	EMEND	CAPS	80MG, 125MG	QL (6 per 30D)
NAUSEA	*granisetron hcl*	TABS	1MG	PN; QL (10 per 30D)
NAUSEA	*granisol oral*	SOLN	2MG/10ML	PN; QL
NAUSEA	*hydroxyzine PNmoate*	CAPS	25MG, 50MG	
NAUSEA	*ondansetron hcl oral*	SOLN	4MG/5ML,	
NAUSEA	*ondansetron hcl*	TABS	24MG	
NAUSEA	*ondansetron/ odt*	TABS	4MG, 8MG	
NAUSEA	*perphenazine*	TABS	2MG, 4MG, 8MG, 16MG	
NAUSEA	*prochloperazine*	TABS	5MG, 10MG	

THERAPEUTIC CLASS	DRUG NAME	FORM	STRENGTH	LIMITS-NOTES
NAUSEA	*promethazine hcl*	TABS	12.5MG, 25MG, 50MG	
NAUSEA	*trimethobenzamide hcl*	CAPS	300MG	
RESPIRATORY	*acetylcysteine*	SOLN	10%, 20%	
RESPIRATORY	*albuterol sulfate*	NEBU	0.083%, 0.5%	
RESPIRATORY	*albuterol sulfate*	NEBU	1.25MG/3ML	PN (generic accuneb)
RESPIRATORY	*albuterol sulfate/ipratropium bromide*	SOLN	2.5MG/3ML; 0.5MG/3ML	
RESPIRATORY	BROVANA	NEBU	15MCG/2ML	PN; QL (120ml per 30D)
RESPIRATORY	*cromolyn sodium*	NEBU	20MG/2ML	
RESPIRATORY	*ipratropium bromide*	SOLN	0.02%	
RESPIRATORY	*metaproterenol sulfate*	NEBU	0.4%, 0.6%	
RESPIRATORY	NEBUPENT	SOLR	300MG	PN
RESPIRATORY	PERFOROMIST	NEBU	20MCG/2ML	PN; QL (120 ml per 30D)
RESPIRATORY	PULMICORT	SUSP	0.25MG/2ML, 0.5MG/2ML,	PN; QL (120 ml per 30D)
RESPIRATORY	PULMICORT	SUSP	1MG/2ML	PN; QL (60ml per 30D)
RESPIRATORY	PULMOZYME	SOLN	1MG/ML	PN
RESPIRATORY	TOBI	NEBU	300MG/5ML	PN; QL (280ml per 28D)
RESPIRATORY	*tobramycin sulfate*	SOLN	80MG/2ML	
RESPIRATORY	VENTAVIS	SOLN	10MCG/ML	PN

THERAPEUTIC CLASS	DRUG NAME	FORM	STRENGTH	LIMITS-NOTES
RESPIRATORY	XOPENEX	NEBU	0.31MG/3ML, 0.63MG/3ML, 1.25MG/3ML	PN
TRANSPLANT	*azathioprine*	TABS	50MG	
TRANSPLANT	CELLCEPT	CAPS	250MG	PN
TRANSPLANT	CELLCEPT	SUSR	200MG/ML	PN
TRANSPLANT	CELLCEPT	TABS	500MG	PN
TRANSPLANT	*cyclosporine*	CAPS	25MG, 50MG, 100MG	PN
TRANSPLANT	*cyclosporine oral*	SOLN	100MG/ML	PN
TRANSPLANT	*dexamethasone*	TABS	0.5MG, 0.75MG, 1MG, 1.5MG, 2MG, 4MG, 6MG	
TRANSPLANT	*gengraf*	CAPS	25MG, 100MG	PN
TRANSPLANT	*gengraf oral*	SOLN	100MG/ML	PN
TRANSPLANT	*methylprednisolone*	TABS	4MG, 8MG, 16MG, 32MG	
TRANSPLANT	MYFORTIC	TBEC	180MG, 360MG	PN
TRANSPLANT	NEORAL	CAPS	25MG, 100MG	PN
TRANSPLANT	NEORAL	SOLN	100MG/ML	PN
TRANSPLANT	*prednisolone*	SYRP	15MG/5ML	
TRANSPLANT	*prednisolone*	TABS	5MG	
TRANSPLANT	*prednisone*	TABS	1MG, 2.5MG, 5MG, 10MG, 20MG, 50MG	

THERAPEUTIC CLASS	DRUG NAME	FORM	STRENGTH	LIMITS-NOTES
TRANSPLANT	PROGRAF	CAPS	0.5MG, 1MG, 5MG	PN
TRANSPLANT	RAPNMUNE	SOLN	1MG/ML	PN
TRANSPLANT	RAPNMUNE	TABS	1MG, 2MG	PN
TRANSPLANT	SANDIMMUNE	CAPS	25MG, 100MG	PN
TRANSPLANT	SANDIMMUNE	SOLN	100MG/ML	PN
VACCINES	FLU VACCINE	SUSP		QL (1.00 per year)
VACCINES	PNEUMOVAX 23	INJ	25MCG/0.5ML	QL (1.00 per year)